CATEGORY: IG.2 IN-GARRISON MEDICAL OPERATIONS

Table of Contents

Area: IG.2.1 Worker Protection

Area: IG.2.2 Dentistry

Area: IG.2.3 Life Skills

Element Identifiers		Life Skills	
New	**Old**	**Element Title**	**Page #**
IG.2.3.1	OPS.7.1.1 OPS.7.1.3 OPS.7.1.4	Life Skills Support Center (LSSC) Leadership: Safety, Risk Management, Confidentiality, Military Law and Commander Directed Evaluations (CDE)	IG 2-44
IG.2.3.2	OPS.7.3.1	Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program	IG 2-46
IG.2.3.3	OPS.7.2.1	Family Advocacy Oversight	IG 2-48
IG.2.3.4	OPS.7.2.2	Family Maltreatment Case Management Team (FMCMT)	IG 2-50
IG.2.3.5	OPS.7.2.5 OPS.7.2.6	Assessment and Care of Family Maltreatment Clients	IG 2-52
IG.2.3.6	OPS.7.2.9	New Parent Support Program	IG 2-54

Area: IG.2.4 Population Health

Element Identifiers		Population Health	
New	**Old**	**Element Title**	**Page #**
IG.2.4.1	LED.2.2.2 OPS.5.2.1 OPS.6.1.1 OPS.6.1.2	Population Health Structure and Process (PHSP)	IG 2-56
IG.2.4.2	LED.2.2.3 OPS.5.2.2	Primary Care Optimization (PCO) Clinical Management	IG 2-59
IG.2.4.3	OPS.7.1.5 OPS.7.2.8	Life Skills Support Center and Community Prevention	IG 2-62
IG.2.4.4	OPS.6.2.1 OPS.6.2.2 OPS.6.2.3 OPS.6.2.6 OPS.6.2.7	Health and Wellness Programs: Alcohol and Substance Abuse Prevention/Stress Management/Tobacco Use Cessation and Prevention/Nutrition Education/ Cardiovascular Disease, Cancer & Other Preventive Efforts	IG 2-64
IG.2.4.5	OPS.5.1.1 OPS.5.1.2	Preventive Dentistry	IG 2-71
IG.2.4.6	OPS.7.3.4	Demand Reduction Program – Drug Testing	IG 2-73
IG.2.4.7	OPS.7.2.7	Special Needs Identification and Assignment Coordination Process [Exceptional Family Member Program (EFMP)]	IG 2-75

Area: IG.2.5 Clinical Services

Element Identifiers		Clinical Services	
New	**Old**	**Element Title**	**Page #**
IG.2.5.1	LED.2.3.4	Professional Services Management	IG 2-76
IG.2.5.2	OPS.1.2.2	Emergency Response: Ambulances and Equipment	IG 2-78
IG.2.5.3	HCS.1.3.3	Health Records Availability and Management	IG 2-80
IG.2.5.4	HCS.1.4.3 HCS.1.4.4 HCS.1.4.5	Pharmacy Management	IG 2-82
IG.2.5.5	HCS.1.4.1 HCS.1.4.2	Medication Security	IG 2-84
IG.2.5.6	OPS.5.4.1	Immunization Services	IG 2-86
IG.2.5.7	LED.2.3.5	Oversight of Nursing Practice	IG 2-88

Area IG.2.1 Worker Protection

Element IG.2.1.1 (formerly OPS.3.3.1)

Occupational Health Medical Examination Administration

Evaluation Criteria

- Documentation reflected an integrated team approach (occupational health working group [OHWG] or aeromedical council [AMC]) to provide professional oversight to the occupational health program
  -- OHWG members were appointed in writing IAW AFI 48-145
  -- A physician was appointed in writing as the occupational health consultant by the AMDS commander (or equivalent) IAW AFI 48-145
- Occupational Safety and Health Administration (OSHA)/AFOSH/NFPA 1582 mandated medical surveillance was addressed
- Justification for occupational medical examinations was documented
- There was consistency of medical monitoring for shops/processes/workers with similar exposures/hazards
- Shop survey, OHWG review, and occupational health medical examination schedules were coordinated so that examinations of workers were based on accurate, current data
- All participants in the occupational health process used forms with current data, and public health, Force Health Management Element, bioenvironmental engineer and worker's medical records all contained the same current version of the AF Form 2755 or equivalent document
- There was an active industrial shop visit program utilizing a team approach (with primary care manager, flight surgeon, bioenvironmental engineering and public health personnel involved) to target critical shops
- Supervisors and commanders were regularly notified of occupational exam completion rates

---

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care.

2: Inconsistencies in shop visits, medical monitoring, or multidisciplinary coordination potentially compromised employee health.

1: Few criteria met. Adverse mission impact was expected to occur.
- There was potential for employee health and safety to be compromised
- There was noncompliance with OSHA or Air Force regulatory requirements

0: The medical unit failed to meet the minimum provisions of the element. Employee health and safety were seriously jeopardized due to failure to identify OSHA mandates, address a significant health hazard in one or more shops, or ineffective medical monitoring of employees.

NA**:** Not scored.

Protocol Flight Surgeon Protocol 3 is the pertinent protocol for this element.

Inspector Contact For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty physician (flight surgeon) inspector.

Reference(s) AFPD 48-1; AFI 48-101; AFI 48-145; AFI 91-301; Interim Guidance, AFI 48-20; DoD 6055.5-M

Element IG.2.1.2 (formerly OPS.3.3.3 and OPS.3.3.6)

Quality of Occupational Health Medical Examinations (OHME) and Follow-Up

---

Evaluation Criteria

- OHMEs were performed IAW locally established AF Form 2766 protocols
- Preplacement exams were done within 60 days of starting work in the shop
- OHMEs were documented in the medical record
  - -- All positive responses on worker health histories were explained and evaluated as appropriate
  - -- Occupational and recreational exposure history was assessed
  - -- Completed medical evaluation questionnaires (29CFR 1910.134, Appendix C) were present in the medical records of workers covered under the respiratory protection program
  - -- A credentialed provider documented review and interpretation of all lab/test results in the member's medical record
- Workers were notified of the results of their occupational exam
- Sustained OHME currency rate (total number of workers who had OHME within the time period specified on the AF Form 2766 divided by the total number of workers requiring OHME) exceeded 90 percent
- OHMEs were completed in a timely fashion (suggested guideline—less than 30 days from initial presentation for uncomplicated exams, or as designated by the medical unit)
- Follow-up of abnormal OHMEs (including audiograms) was documented through closure
  - -- Abnormal OHME follow-up was accomplished IAW applicable administrative and clinical guidelines
  - -- Abnormal OHME follow-up activities were documented in the medical record
- Mechanisms for dealing with worker injury/illness and unexpected or abnormal biological monitoring tests existed
  - -- Structured approach existed to determine whether illness or injury may have resulted from inadequate safety controls
  - -- Results of safety investigations led to process modifications designed to decrease the likelihood of a similar incident
- Medical personnel are required to provide medical evaluation or render medical opinion on information provided by private physician to determine an appropriate course of action in any fitness for duty or disability evaluation
  - -- Evaluations considered individual's ability to safely and effectively perform duties required by the job in the specific work place environment and were appropriately documented
  - -- Conditions and expected time frames were established for return to duty

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care. The sustained OHME compliance rate was less than 90 percent.

2: Potential adverse health effects may have gone unnoticed due to a sustained OHME compliance rate less than 80 percent or failure to follow AF Form 2766 protocols.

1. The health and safety of workers was jeopardized by a sustained OHME compliance rate of less than 70 percent. There was a failure to address or follow up on abnormal findings during the OHME.

0: The medical unit failed to meet the minimum provisions of the element. There was failure to follow AF Form 2766 protocols in multiple critical shops or failure to follow up on significant abnormal findings during the OHME.

NA**:** Not scored.

Protocol

Flight Surgeon Protocol 3 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty physician (flight surgeon) inspector.

Reference(s)

AFPD 48-1; AFI 48-101; AFI 48-145; 29 CFR 1910.95 section 8, Follow-up Procedures; AFI 48-123, Chap 17; AFOSH 48-137; AFI 48-20, Interim Guidance, 7 Apr 00; DoD 6055.5-M

Element IG.2.1.3 (formerly OPS.3.3.4)

Hearing Conservation Program (HCP) — Clinical Aspects

Evaluation Criteria

- Individuals with standard threshold shifts (STS) were referred for hearing protection reeducation and refitting at the initial examination showing an STS (29 CRF 1910.95 (g)(8)(ii) through (g)(8)(ii)(B))
- All individuals with permanent threshold shifts (PTS) were referred to an audiologist
  -- Civilian and DoD referral audiology evaluations were comparable to hearing conservation diagnostic center (HCDC) or Hearing Conservation Center (HCC) evaluations
  -- Evaluations were sufficient to eliminate conductive or retrocochlear pathology
  -- A sampling of these non-HCDC evaluations/dispositions were forwarded to the regional HCDC or HCC for oversight review
- Fitness and risk determinations were performed when indicated
- Automated audiometry equipment was calibrated before use and DOEHRS data submitted to the Defense Occupational Environmental Health Readiness System Data Repository on a monthly basis
- The interval between the initial shift and completion of new baselines was 30 days with written notification of the STS to the patient completed within 21 days of determination of PTS
  -- A tracking mechanism existed to ensure follow-up to STSs were accomplished
- AF Form 1753 (Hearing Conservation Examination) was completed upon initial entry into the HCP and when an STS persisted upon completion of follow-up testing

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care.

2: Patients may have been placed at risk for adverse outcomes. For example:
- There were at least two workers whose follow-up was not completed within 30 days of the annual audiogram
- There were at least two workers without evidence of re-education/refitting at the time of the initial threshold shift

1: Adverse mission impact was likely due to failure to consistently follow workers with threshold shifts. For example:
- There were at least 3-5 workers whose follow-up was not completed within 30 days of the annual audiogram

- There were 3-5 workers without evidence of re-education/refitting at the time of the initial threshold shift

0: The medical unit failed to adequately follow workers with threshold shifts and loss of personnel resources was highly likely. For example:
- There were six or more workers whose follow-up was not completed within 30 days of the annual audiogram
- There were six or more workers without evidence of re-education/refitting at the time of the initial threshold shift

NA**:** Not scored.

Protocol

Flight Surgeon Protocol 3 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty public health or physician (flight surgeon) inspector.

Reference(s)

AFI 48-145; AFOSH 48-19; HQ AFMOA/SGPA memorandum, Changes to AFOSH Std 161-20, Hearing Conservation Program, Regarding the Detailed Follow-up Program, 30 Mar 95; AL/OEM memorandum, Hearing Conservation Diagnostic Center (HCDC) Referrals, Apr 95; HQ AFMOA/ SGO memorandum, Vision/Hearing Standards & Certification/Waiver Table, 24 Apr 97; AFI 48-20, Interim Guidance, 7 Apr 00; AFELM MED DoD memorandum, Proper Use of AF Form 1753, 16 Oct 00

The criteria in the table below can be utilized by units with either a hearing conservation diagnostic center (HCDC) or hearing conservation center (HCC):

HCDC	HCC
- Capabilities included pure-tone, air and bone conduction threshold testing, speech and impedance audiometry, evoked response audiometry, site of lesion testing and issuance and maintenance of hearing aids - Minimum staffing consisted of an audiologist and an otolaryngologist - AF Forms 1672, (Hearing Conservation Diagnostic Center referral) were used for referrals and completed appropriately - The HCDC, when requested by a field medical unit, reviewed outside DoD or civilian evaluations, identified appropriate baselines, and gave feedback to the referral medical unit - Evaluations were accomplished in a reasonable period of time (30 days or the TRICARE access standard, whichever is longer)	- Capabilities included pure-tone, air and bone conduction threshold testing, speech and impedance audiometry, evoked response audiometry and site of lesion testing - Minimum staffing consisted of an audiologist - AF Forms 1672, (Hearing Conservation Diagnostic Center Referral) were used for referrals and completed appropriately - Evaluations were accomplished in a reasonable period of time (30 days or the TRICARE access standard, whichever is longer) - The HCC managed the hearing conservation program - The HCC audiologist worked closely with bioenvironmental engineer (BE) and public health (PH) to identify areas with high risk of occupational hazardous noise exposure -- The HCC audiologist periodically conducted medical worksite visits of hazardous noise areas (routine visits, investigational purposes such as fitness and risk evaluations, education, etc.) -- The HCC audiologist, working with PH and occupational medicine service, analyzed hearing threshold shifts to identify high risk jobs and areas where further noise control measures or additional education may have been needed -- The HCC audiologist reported hearing threshold shift trends to the AMC, aerospace medicine squadron commander, medical unit commander and installation squadron commanders, as appropriate -- The HCC audiologist was a member of the occupational health oversight group, occupational health working group

Data Collection Tool

The table below contains the information used by inspectors during their hearing conservation program record reviews. It may be helpful to utilize this table during self-evaluation efforts.

Hearing Conservation Case Tracking			
RECORD I.D. (INITIALS/LAST 4)			
Date initial STS identified			
STS fitted/educated, hearing protection device attenuation issues addressed			
Employee notified of initial shift within 21 days			
1st noise-free F/U performed			
2nd noise-free F/U performed			
Date letter sent to supervisor after PTS Dx			
Worker referred to HC (D) C			
HC(D)C evaluation on file			
Final FS consultant progress note			
HC(D)C recommendations followed			
Average # days to conclusion, for all workers in the tracking log for the last 12-24 months, please show denominator			

"+"= PRESENT "-" = NOT PRESENT "NA" = NOT APPLICABLE
Provide dates where available

Element IG.2.1.4 (formerly OPS.3.4.3)

Communicable Disease Monitoring in Medical Unit Workers

Evaluation Criteria

- Medical unit workers were screened for communicable diseases prior to starting work and periodically, as required
  - -- Exposure-prone and high risk workers were tested annually for HIV
  - -- Exposure-prone personnel know their HBsAg status and, if positive, were medically evaluated and referred to the credentials committee
  - -- Health care practitioners who are at ongoing risk for percutaneous injuries were tested 1-2 months after completion of the 3-dose HBV vaccination series for anti-HBs (including a look-back program for personnel immunized since Dec 97)
- Screening requirements were based upon local diseases of concern in the medical unit environment and those required by AF directives
- Screening and follow-up were documented
- Mechanisms were in place to identify, duty restrict and reinstate medical unit workers acquiring communicable conditions
- Communicable disease trends in medical unit workers were analyzed and appropriate actions were taken
- Public health reported medical unit worker communicable disease surveillance data to the medical unit infection control forum as required/requested
- Program activities were documented

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise mission support. Adverse population or individual health outcomes are not anticipated.

2: Not all criteria met. Program outcomes may be adversely affected. Patients and staff may have been placed at risk of contracting communicable diseases.

1: Few criteria met. Adverse mission impact was expected to occur. There was strong potential for patients/staff to contract communicable diseases.

0: There was noncompliance with standards. The medical unit failed to meet the minimum provisions of the element. Adverse mission impact occurred or was highly likely to occur. Patients and staff were likely to contract communicable diseases, or nosocomial infections were known to have occurred.

NA**:** Not scored.

Protocol Public Health Protocol 4 is the pertinent protocol for this element.

Inspector Contact For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty public health inspector.

Reference(s) AFPD 48-1; AFI 44-108; AFI 48-101; MMWR 50, RR-11, 29 Jun 01; MMWR 40, RR-08, 12 Jul 91; Epidemiology and Prevention of Vaccine Preventable Diseases, 7th Ed.; HQ USAF/SG memorandum, Hepatitis B Immunization Policy for Air Force Medical and Dental Personnel, 15 Jan 97

Data Collection Tool The table below contains the information used by inspectors during their health care worker record reviews. It may be helpful to utilize this table during self-evaluation efforts.

	Exposure Prone Worker	High Risk Worker
RECORD I.D. (INITIALS/LAST 4)		
Hep B vaccination given		
HBsAG testing accomplished		
HIV testing accomplished		

"+" = PRESENT "-" = NOT PRESENT "NA" = NOT APPLICABLE
Provide dates where applicable

Element IG.2.1.5 (formerly OPS.3.4.1)

Medical Unit Bloodborne Pathogen Program

Evaluation Criteria

- There was a written exposure control plan (reviewed annually) for controlling bloodborne pathogen exposures
- At-risk personnel received pre-employment and recurrent training
- Training scope and content was IAW specific local exposure control plan guidelines and general 29 CFR 1910.1030, section (g)(2)(vii), directives
  -- At-risk medical unit employees, contractors, volunteers and trainees were appropriately classified into high risk or exposure-prone categories
- HBV immunizations were mandated and provided at no cost within 10 days of initial assignment for at-risk active duty workers and civilian/contract workers (including trainees, volunteers, and other temporary staff) as a condition of employment
- The medical unit assisted base agencies in bloodborne pathogens program implementation
- Bloodborne pathogen exposure incidents were documented (while tracking logs, computer databases and worksheets are important to management of this program, continuity of care must be clearly discernible in the medical record)
  -- Exposure data was trended and reported to the infection control committee or infection control review function
  -- A health care professional's written opinion was provided to the potentially exposed worker within 15 working days of completion of the original evaluation [content of the written opinion will be in accordance with 29 CFR 1910.1030, section (f)(5)]
  -- HIV and hepatitis B post-exposure prophylaxis protocols followed current Centers for Disease Control and AF guidelines

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care. Adverse population or individual health outcomes are not anticipated.

2: Some, but not all criteria met. Program outcomes may be adversely affected. There was an increased risk of unrecognized exposure of patients or staff to bloodborne pathogens.

1: Few criteria met. Adverse mission impact was expected to occur.
- There was the potential for employee health/safety to be compromised
- There was substantial noncompliance with OSHA or Air Force regulatory requirements

0: There was noncompliance with standards. The medical unit failed to meet the minimum provisions of the element. Adverse mission impact occurred or was highly likely to occur. There was a high potential for employee and patient health and safety to be compromised. For example, there was noncompliance with OSHA or AF regulatory requirements.

NA**:** Not scored.

Protocol

Public Health Protocol 4 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty public health inspector.

Reference(s)

AFI 44-108; 29 CFR 1910.1030; Occupational Safety and Health Administration Instruction CPL 2-2.44D; HQ USAF/SG memorandum, Hepatitis B Immunization Policy for Air Force Medical and Dental Personnel, 15 Jan 97; MMWR 47, RR-7, 15 May 98; MMWR 47, RR-19, 16 Oct 98; MMWR 40, RR-8, 12 Jul 91; MMWR 50, RR-11, 29 Jun 01; HQ USAF/SG memorandum, Guidance for MTFs in Response to Policy Letter on Needlestick Safety for Health Care Workers (HA Policy 01-013), 8 Nov 01

Data Collection Tool The table below contains the information used by inspectors during their health care worker record reviews. It may be helpful to utilize this table during self-evaluation efforts.

Bloodborne Pathogen Exposure Cases		
RECORD I.D. (INITIALS/LAST 4)		
Bloodborne pathogen exposure evaluated IAW OSHA guidelines		
HCP Evaluated, follow-up, treatment plan in medical record		
Patient Hep B vaccine and antibody status annotated in medical record		
Source blood tested IAW CDC guidelines		
Patient's blood tested IAW CDC guidelines		
HCP written opinion provided to patient within 15 days of exposure		
HCP written opinion in the medical record		
Patient f/u accomplished as requested by provider		

"+" = PRESENT "-" = NOT PRESENT "NA" = NOT APPLICABLE
Provide dates where applicable

Element IG.2.1.6 (formerly OPS.3.3.5)

Reproductive Health/Fetal Protection

Evaluation Criteria

- Reproductive hazard assessment:
  - -- Attending providers consulted flight surgeon office (FSO), bioenvironmental engineer (BE) and public health (PH) personnel regarding occupational exposures to potential reproductive hazards in military personnel and AF-employed civilian workers
  - -- Reproductive hazard assessments were performed as early as possible in the pregnancy (mechanisms were in place to ensure FSO, BE and PH personnel became aware of pregnancy diagnoses soon after confirmation; hazard assessments were not delayed)
  - -- Military personnel and AF-employed civilian pregnant workers were interviewed to assess hazard exposure potential
  - -- The BE exposure assessments targeted specific hazards and information provided is consistent with regulatory guidance and AF technical orders
- Reproductive health/fetal protection education:
  - -- Specific industrial reproductive hazards were addressed to the worker
  - -- Pregnant workers received individualized fetal protection education soon after diagnosis
  - -- Pregnant worker education considered occupational and non-occupational environmental risks
- Pregnancy profiling:
  - -- For civilian and military members, profiles reflected recommendations resulting from a current comprehensive hazard assessment
  - -- Standard (chemical warfare defense ensemble wear, etc.) and targeted (ionizing radiation, chemotherapeutics, lead, etc.) duty restrictions were hazard specific
  - -- Duty restrictions were coordinated with the pregnant worker, her supervisor and the attending provider
  - -- Profiles were generated expediently
    - --- Reasonable completion times (from date of positive HCG until profile distribution) could be 1 to 3 days for administrative workplaces and 5 days for industrial workplaces
    - --- Completion times greater than 10 days were closely scrutinized
  - -- A process exists in facilities referring pregnancy management to off-base DoD providers to ensure industrial workers (active duty, Air Reserve Component and civilian government employees) are advised of appropriate work restrictions within a reasonable time of a positive HCG
- Reproductive health/fetal protection activities were documented (while tracking logs, computer databases and worksheets are important to management of this program, continuity of care must be clearly discernible in the medical record)
- Adherence to standard of care was clearly discernible in the medical record

Scoring	4: Criteria met. 3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise mission support or patient health. 2: There was an increased potential for unrecognized fetal/maternal exposures to potentially hazardous situations. 1: Failure to adequately manage the fetal protection program was likely to have adverse mission impact or pose significant risks to fetal or maternal health. 0: The medical unit failed to provide appropriate fetal protection. There was a high potential for adverse fetal/maternal outcomes due to unrecognized exposures to potentially hazardous situations, or an adverse outcome was known to have occurred. NA**:** Not scored.
Protocol	Flight Surgeon Protocol 3 is the pertinent protocol for this element.
Inspector Contact	For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty public health or physician (flight surgeon) inspector.
Reference(s)	10 CFR 835.206; AFPD 48-1; AFI 48-101; AFI 44-102; AFI 48-125; AFI 48-145; OSHA 2254, Training Requirements in OSHA Standards and Training Guidelines

Data Collection Tool The table below contains the information used by inspectors during their reproductive health and fetal protection record reviews. It may be helpful to utilize this table during self-evaluation efforts.

Reproductive Health and Fetal Protection Data Collection Tool			
RECORD I.D. (INITIALS/LAST 4)			
Industrial (vs. administrative) shop			
Date of positive HCG (as documented in the medical record)			
Date of OB/GYN referral to PH			
Date PH interviewed pregnant worker			
Pregnant worker education provided for potential exposures			
Supervisor interviewed			
Date BE assessed potential exposures			
Date PH completed and forwarded SF 513			
Profile reflected restriction recommendations			
"Targeted" restrictions were hazard specific			
Date profile completed			
Average time from HCG to Profile for all cases in the tracking log for the past 12-24 months (please show the denominator)			

"+" = PRESENT "-" = NOT PRESENT "NA" = NOT APPLICABLE
Provide dates where applicable

Element IG.2.1.7 (formerly OPS.3.4.2)

Medical Unit Occupational Exposure to Tuberculosis

Evaluation Criteria

- A multidisciplinary group within the medical unit conducted a tuberculosis (TB) risk assessment and developed/implemented written TB exposure control guidelines (reviewed annually) using Centers for Disease Control (CDC)/Occupational Safety and Health Administration (OSHA)/AF guidelines
  - -- Medical unit guidelines addressed:
    - --- How to conduct the TB risk assessment
    - --- Identification of at-risk personnel
    - --- Case definition for suspected active TB
    - --- Education provided upon initial assignment which included TB epidemiology, pathogenesis, occupational risk and work practices that reduce transmission
    - --- Appropriate personal protective equipment (PPE), including a functional respiratory protection program for preventing occupational exposure to TB; bioenvironmental engineer (BE) involved in TB exposure respiratory protection decision
    - --- Appropriate engineering controls (ventilation systems) and the periodic monitoring of these systems
    - --- Appropriate patient isolation and transportation
    - --- Treatment facility infection clusters and follow-up testing
    - --- Other control measures as appropriate
- Health care workers' TB skin testing frequency was IAW CDC and AF guidelines (e.g., annual testing for personnel working in medical treatment facilities and semi-annually for high-risk personnel)
- For medical unit personnel, latent TB infections (positive TB skin tests) and TB disease (active TB) were recorded on the OSHA Form 300 or AF Form 739 or equivalent
- Workers demonstrating a positive TB test were entered into a treatment program or appropriately managed

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise mission support. Adverse population or individual health outcomes are not anticipated.

2: Not all criteria met. Program outcomes may be adversely affected. For example, deficiencies existed in the written guidelines for TB exposure control, training or related documentation of worker knowledge, resulting in inadequate communication of TB hazard information to workers.

1: Adverse mission impact was expected to occur. There was the potential for employee health and safety to be compromised.

0: There was noncompliance with standards. The medical unit failed to meet the minimum provisions of the element. Adverse mission impact occurred or was highly likely to occur. There was a high potential for employee health and safety to be compromised. For example, there was noncompliance with OSHA or AF regulatory requirements, or clusters of TB skin test conversions were known to have occurred in medical unit employees.

NA**:** Not scored.

Protocol

Public Health Protocol 4 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty public health inspector.

Reference(s)

AFOSH 48-137; AFPD 48-1; AFI 44-108; AFI 48-101; HQ USAF/SG memorandum, Occupational Exposure to Tuberculosis, Apr 94; MMWR Vol. 43/No. RR-13, 28 Oct 94; Occupational Safety and Health Administration Instruction CPL 2.106, Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis, 9 Feb 96

Data Collection Tool The table below contains the information used by inspectors during their tuberculosis exposure control plan reviews. It may be helpful to utilize this table during self-evaluation efforts.

TB Exposure Control Plan Review			
Element		**Present**	
	Needed	**Yes**	**No**
Assigning responsibility (Section II.A)	X		
Risk assessment (Section II.B.1)	X		
TB infection control plan (Section II.B.2)	X		
Periodically reassess risk (Section II.B.3)	X		
Identifying, evaluating, and initiating treatment for patients who may have active TB (Section II.C)	X		
Managing patients who may have TB in ambulatory- care settings and emergency departments (Section II.D) Triage system; Protocol to manage active TB, referring patients	X		
Managing hospitalized TB patients (Section II.E)			
Engineering controls (Suppl 3, Section II.F)			
Respiratory protection (Suppl 4, Section II.G)	X		
Aerosol-generating procedures (Section II.H)	X		
Educating and Training HCWs (Section II.I)	X		
Counseling and screening HCWs (Section II.J) Counseling HCWs regarding TB; identifying, evaluating HCWs with signs of active TB; baseline, periodic PPD testing; evaluating, managing (+) PPD; managing HCWs with active TB	X		
Conducting a problem evaluation (Section II.K) Investigate clusters, patient to patient transmission	X		
Coordination with the public health department (Section II.L)	X		

Element IG.2.1.8 (formerly OPS.3.2.9)

Occupational Health Education Activities

Evaluation Criteria

- The occupational health working group:
  - -- Established, documented and communicated worker education requirements to supervisors
  - -- Arranged and conducted training for supervisors on health hazards (e.g., chemical, physical and biological) identified as presenting a potential health risk
  - -- Provided technical assistance to supervisors conducting training, as needed
  - -- Ensured training programs (including expanded standards) met Occupational Safety and Health Administration (OSHA) requirements
  - -- Used trends to identify critical areas for education efforts
  - -- Developed a risk-based approach to ergonomics that included education and training
  - -- Ensured work places where emergency medical response is an additional duty were included in the bloodborne pathogens control program
- Public Health provided HAZCOM "train-the-trainer" programs for supervisors
- For hazardous noise
  - -- Initial education and training was provided to hazardous noise-exposed personnel (within 6 months of assignment)
  - -- Annual training was provided to supervisors of work places in hazardous noise areas who, in turn, provided annual training to employees
  - -- Re-education and refitting (including documentation of noise attenuation afforded by the personal protective equipment recommended) was accomplished after the initial audiogram indicated a threshold shift
    - --- Employee informed of significant (standard) threshold shift (STS) in writing, within 21 days of the determination; supervisor informed after permanent threshold shift determined
    - --- Workers were issued and trained in the use of bioenvironmental engineer-recommended hearing protection devices, and type/size of protection devices was documented (DD Form 2215, AF Form 2767, SF 600, etc.)
- Education efforts included workers right to medical and exposure records
- Education activities were documented
- The public health office provided support to ARC and IMAs IAW host-tenant support agreement(s)

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise mission support. Adverse population or individual health outcomes are not anticipated.

2: Some, but not all criteria met. Program outcomes may be adversely affected.

1: Few criteria met. Adverse mission impact was expected to occur.
- There was the potential for employee health and safety to be compromised
- There was substantial noncompliance with OSHA or AF regulatory requirements

0: There was noncompliance with standards. The medical unit failed to meet the minimum provisions of the element. Adverse mission impact occurred or was highly likely to occur. There was a high potential for employee health and safety to be compromised or there was noncompliance with OSHA or AF regulatory requirements.

NA**:** Not scored.

Protocol Flight Surgeon Protocol 3 is the pertinent protocol for this element.

Inspector Contact For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty public health inspector.

Reference(s) 29 CFR 1910.95; 29 CFR 1910.20 (Occupational Safety and Health Administration Handout 3110); 29 CFR 1910.1200; DoD 6055.5-M; AFPD 48-1; AFI 48-101; AFI 48-145; AFI 91-301; AFOSH Std 48-8; AFMOA/CC memorandum, Air Force Ergonomic Program, 6 Mar 98; OSHA 2254, Training Requirements in OSHA Standards and Training Guidelines

Area IG.2.2 Dentistry

Element IG.2.2.1 (formerly OPS.8.2.1)

Periodic Dental Examinations

Evaluation Criteria

- Periodic examinations (Type 1 or Type 2) were performed on all AF personnel to assess readiness status
- Mechanisms were in place to ensure examination rosters were produced and received at least monthly
- The periodontal screening and recording (PSR) system was used
- The dental caries risk assessment was used
- Patients with significant, unresolved, or previously undiscovered medical findings were referred for evaluation

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care.

2: Significant deficiencies existed in the Periodic Dental Examination program. Program outcomes may be adversely affected.

1: Few criteria met. The Periodic Dental Examination program had not demonstrated long-term sustainment. Adverse mission impact was likely to occur.

0: Criteria not met. The unit failed to meet the minimum provisions of the element. Adverse mission impact occurred or was highly likely to occur.

NA: Not scored.

Protocol

Dental Protocol 3 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty dental inspector.

Reference(s)

AFI 47-101

Element IG.2.2.2 (formerly OPS.8.4.2)

Delivery of Non-Emergent Dental Care

Evaluation Criteria

- In the interest of maintaining competency, all credentialed dentists assigned to the unit practiced dentistry on a regular basis
- Leadership ensured enlisted manning was appropriately utilized to support the delivery of dental care
- Treatment planning was incorporated into each patient record
  - -- Patients requiring extensive or multidisciplinary treatment were assigned a primary dental officer to develop a comprehensive treatment plan and coordinate treatment
  - -- A system for monitoring the progress of patients requiring multidisciplinary care was being used
  - -- A process was in place to identify and manage high caries risk patients
- In facilities containing dental specialties, a system for rotations of general dental officers through those specialties existed or professional mentorship on complex cases was formally provided by additionally trained general dentists
- A biopsy tracking system was in place and patient notifications were made as required
- When family member overseas clearance examinations were required, they occurred in a timely manner and with appropriate evaluation and recommendations provided
- Plans and processes were in place to provide timely postmortem identification services
  - -- Appropriate forms were available for identification documentation
- When patients refused dental care, actions were taken IAW AF instructions and local policies

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care.

2: Personnel were not appropriately used to support patient care. Multidisciplinary cases or high caries risk patients were not consistently managed. Rotation or professional mentorship programs for general dental officers were minimal or non-existent.

1: Few criteria were met. Key functions, including treatment planning, management of high-caries risk patients, biopsy tracking, family member overseas clearance or forensic dental services were inadequate or lacking. Adverse mission impact or compromise of patient care was likely to occur.

0: Criteria not met. The unit failed to meet the minimum provisions of the element. Key functions including treatment planning, biopsy tracking, family member overseas clearance and forensic dental services were lacking. Adverse mission impact or compromise of patient care occurred or was highly likely to occur.

NA: Not scored.

Protocol Dental Protocol 4 is the pertinent protocol for this element.

Inspector Contact For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty dental inspector.

Reference(s) AFI 47-101; USAF Dental Clinical Practice Guidelines

Element IG.2.2.3 (formerly OPS.8.3.1)

Consultations/Referrals Management

Evaluation Criteria

- Hypertension screening was accomplished as appropriate
  - -- Criteria were established, and coordinated with the medical staff, defining hypertension parameters and management of patients with elevated blood pressures
- Local procedures were in place for referral and follow-up of patients requiring medical consultation. A mechanism was in place to:
  - -- Monitor the return of consultations
  - -- Facilitate the timely return of consultations
- Dentistry needed beyond the scope of care offered by the clinic, or temporarily unavailable, was appropriately referred, followed and documented

Scoring

4: Criteria met.

3: Deficiencies were minor and unlikely to compromise either mission support or patient care.

2: Although a consultation program was in place, insufficient oversight led to consultation return rates that were not acceptable, potentially causing treatment delays and adverse patient outcomes.

1: Few criteria met. Although elements of a consultation program existed, the program was undeveloped and ineffective. Numerous consults remained unanswered for extended periods of time, causing treatment delays. Adverse mission impact and compromise of patient care were likely to occur.

0: Criteria not met. The unit failed to meet the minimum provisions of the element. No viable hypertension and consultation management program existed. Adverse mission impact and compromise of patient care occurred or were highly likely to occur.

NA: Not scored.

Protocol

Dental Protocol 4 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty dental inspector.

Reference(s)

AFI 47-101; USAF Dental Clinical Practice Guidelines

Element IG.2.2.4 (formerly OPS.8.4.1)

Urgent and Emergent Dental Care

Evaluation Criteria

- Local policies were established for treatment of urgent and emergent dental needs during duty hours
- Local policies were established for the management and treatment of patients seeking after-hours dental care for emergencies
- Local, after-hours care policies were in accordance with AF directives and AF/SGD guidance
- The Dental Charge of Quarters (DCQ) or other appropriate chaperone (e.g., medical technician or nurse) was present during all after-hours visits
- Responsibility for after-hours care was equitably distributed among all credentialed dentists in accordance with a locally agreed upon schedule
- Teaching staff were available on-call to support dental residents providing after-hours emergency care
  - -- A roster of teaching staff on-call by telephone or beeper was maintained to support dental residents
  - -- Documentation of after-hours emergency care provided by residents was reviewed and signed by the staff member on-call or by a designated dental officer
- Delivery and documentation of after-hours care was appropriate

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care.

2: Access to, and management of, urgent and/or emergent dental care was not always fully responsive to the needs of the beneficiary population. After normal duty hours care was not equitably distributed among the professional staff and/or documentation of after-hours care was incomplete.

1: Few criteria met. Access to urgent and/or emergent dental care was adversely affected. Where there was a residency program, teaching staff were not available on-call to mentor residents. DCQ or other appropriate chaperone was not always present for after-hours care. Adverse mission impact and/or compromise of patient care were likely to occur.

0: Criteria not met. The unit failed to meet the minimum provisions of the element. No policies were established for the management and treatment of patients seeking after-hours dental care. Adverse mission impact and/or compromise of patient care occurred or were highly likely to occur.

	NA: Not scored.
Protocol	Dental Protocol 4 is the pertinent protocol for this element.
Inspector Contact	For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty dental inspector.
Reference(s)	AFI 47-101, Chap 6; HQ USAF/AFMOA memorandum, USAF Dental Clinical Practice Guidelines, 17 Sep 98

Element IG.2.2.5 (formerly OPS.8.2.3)

Management of Access to Dental Care

Evaluation Criteria

- A published policy was in place that defined the priority of care and was IAW local and AF directives
- The chief of dental services ensured comprehensive dental treatment/dental examinations were readily available using the following mechanisms:
  - -- Staffing shortfalls were alleviated through coordination with MAJCOM, use of locally available care, or use of supplemental funding
  - -- Appointment/examination utilization was measured and used to maximize clinic efficiency
  - -- A mechanism was in place to ensure acceptable appointment/ examination availability for family members in overseas locations where care is space-required
- Periodic dental examinations were combined with oral prophylaxis appointments for rated personnel, geographically separated unit (GSU) personnel and, to the greatest extent possible, other active duty members
  - -- The MAJCOM/SGD was notified when combined appointments could not be provided to rated members and personnel stationed at GSUs

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or quality of care.

2: Significant deficiencies existed in the management of access to dental care, including limited appointment availability and/or inconsistent use of combined dental examination/prophylaxis appointments. Program outcomes may be adversely affected.

1: Few criteria met. Management of access to dental care was ineffective, resulting in unacceptable appointment availability and delays in care. Periodic dental examinations were not combined with prophylaxis appointments. Adverse mission impact and/or compromise of patient care were likely to occur.

0: Criteria not met. The unit failed to meet the minimum provisions of the element. Oversight of access to dental care was absent or ineffective. MAJCOM had not been notified regarding unacceptable appointment availability or the inability to combine periodic dental examinations with prophylaxis appointments. Adverse mission impact and/or compromise of patient care occurred or were highly likely to occur.

	NA: Not scored.
Protocol	Dental Protocol 3 is the pertinent protocol for this element.
Inspector Contact	For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty dental inspector.
Reference(s)	AFI 47-101; ALMAJCOM letter, 30 Jul 01

Element IG.2.2.6 (formerly OPS.8.5.1 and OPS.8.5.2)

Dental Laboratory Support of Clinic Needs

Evaluation Criteria

- Prosthetic fabrication timelines were established and distributed to providers enabling them to effectively support patient appointment schedules
- A program was in place to monitor timeliness of laboratory products
- Data obtained from monitoring laboratory functions were utilized to improve timeliness of laboratory production
- Excess capability was utilized, as appropriate, to assist other USAF and eligible federal facilities with their laboratory workload
- The safekeeping, inventory, turn-in and documentation of precious metals and alloys was systematic and accurate
- A quality review of productivity data was completed to ensure dental service report accuracy
- There was a program to assess the quality of products fabricated in the dental laboratory
  -- Quality control analysis was used to determine professional needs of laboratory technicians
- The educational and technical needs of laboratory staff members were addressed
- Dental lab personnel used services of available dental laboratory consultants as appropriate

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care.

2: Significant deficiencies existed with dental laboratory support of clinic needs. Fabrication timelines did not effectively support patient appointment schedules, or laboratory resources were not effectively utilized. Quality control measures did not effectively identify training needs for laboratory personnel. Program outcomes may be adversely affected.

1: Few criteria were met. There was no effective program to monitor fabrication timelines or to optimize workload. There was no effective program to assess the quality of products or training needs. There were discrepancies in the safekeeping or documentation of precious metals. Adverse mission impact was likely to occur.

0: Criteria not met. The unit failed to meet the minimum provisions of the element. Dental laboratory productivity, timeliness and/or quality of products failed to meet minimum needs of the professional staff. Adverse mission impact occurred or was highly likely to occur.

NA: Not scored.

Protocol Dental Protocol 2 is the pertinent protocol for this element.

Inspector Contact For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty dental inspector.

Reference(s) AFI 47-101, Chap 7

Element IG.2.2.7 (formerly OPS.8.3.2)

Dental Diagnostic Imaging

Evaluation Criteria

- Radiographic equipment and facilities were properly maintained and serviced with required surveys accomplished. Reports were available for review
- Effective radiographic quality controls were established
  - -- All radiographs were prescribed by a dentist
  - -- Didactic and practical training were under close supervision
  - -- Technicians were certified proficient in producing diagnostic radiographs prior to being assigned without supervision in radiology
  - -- A program was established to ensure periodic competency of dental enlisted and/or civilian members involved in taking radiographs
  - -- As low as reasonably achievable (ALARA) training for health care workers occurred as required
  - -- Retake rates were calculated and monitored and utilized as a training tool
- Other radiology safety issues required by local, state, ALARA and other federal directives were addressed for both health care workers and patients
  - -- Protective aprons were available and used
  - -- Protective aprons were serviceable and visually evaluated for defects at least annually
- Thermoluminescent dosimetry (TLD) badges:
  - -- Were issued to dental staff members when required
  - -- Were properly worn/monitored when indicated

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care.

2: There were significant deficiencies in the radiology program. Documentation of equipment maintenance was lacking, some aspects of quality control were not addressed, or not all training had been accomplished. Program outcomes may be adversely affected.

1: Few criteria were met. There was failure to fully comply with safety standards, training requirements, or quality control objectives. Adverse mission impact was likely to occur.

0: Criteria not met. The unit failed to meet the minimum provisions of the element. Multiple quality and/or safety related issues existed, and adverse mission impact occurred or was highly likely to occur.

	NA**:** Not scored.
Protocol	Dental Protocol 4 is the pertinent protocol for this element.
Inspector Contact	For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty dental inspector.
Reference(s)	AFI 47-101; AFI 48-125

Element IG.2.2.8 (formerly OPS.8.1.2)

Dental Treatment Forms Documentation and Discipline

Evaluation Criteria

- Records were in good repair
- Standard Form 603/603A was appropriately accomplished and:
  - -- Was used to record all dental treatment provided
  - -- Contained legible entries
  - -- Contained entries SIGNED by the provider
  - -- Properly documented the admission and management of dental inpatients
  - -- Contained only authorized designations and abbreviations
  - -- Contained properly completed section I, including items 4 and 5
  - -- Reflected properly completed charting to accurately document treatment
  - -- Contained documents/forms in proper sequence
  - -- Contained entries that reflected complete documentation consisting of a clear diagnosis, treatment and patient disposition
  - -- Contained documentation in the dental health record that showed evidence of appropriate follow-up and continuity of care
- Air Force Form 696, Dental Patient Medical History:
  - -- Was completed on all patients at the periodic dental examination
  - -- Was re-accomplished if there were significant changes in the patient's health status
  - -- Contained dentist evaluation and documentation of all positive entries
- Air Force Forms 644 or 644B were properly completed. Forms:
  - -- Contained the notation, "see SF603/603A" when recording treatment information directly onto the patient's SF 603/603A
  - -- Contained appropriate and accurate recording of American Dental Association (ADA) treatment codes
  - -- Contained thorough, accurate documentation of after-hours patient encounters
- Other treatment forms, e.g. AF Form 1417, AF Form 935, were correctly accomplished

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care.

2: Records exhibited a pattern of uncorrected errors including spelling, illegibility of entries, use of improper abbreviations, and lack of provider signatures. Program outcomes may be adversely affected.

1: Frequent documentation errors including inadequate or inaccurate documentation of diagnosis and treatment, and/or failure to review the

health history increased the medicolegal risk to the Air Force. Adverse mission impact and/or compromise of patient care were likely to occur.

0: The unit failed to meet the minimum provisions of the element. Meaningful treatment documentation practices did not exist and significant medicolegal risk to the Air Force was evident. Adverse mission impact and/or compromise of patient care occurred or were highly likely to occur.

NA: Not scored.

Protocol Dental Protocol 5 is the pertinent protocol for this element.

Inspector Contact For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty dental inspector.

Reference(s) AFI 47-101

Element IG.2.2.9 (formerly OPS.8.1.1)

Management and Control of Dental Health Records

Evaluation Criteria

- Maintenance, storage, and security of AF Form 2100B Series folders were appropriate
- Records were identified with the name of the medical unit having custodial responsibility by attaching a self-adhesive label in the lower right corner on the front of the dental record folder
- Dental records of personnel separating from active duty were documented appropriately
- Locally initiated dental records of other uniformed service members were properly screened and annotated
- An annual inventory of dental records was accomplished to:
  - -- Verify the dental readiness classification and last update of AF members
  - -- Identify and forward retained records of departed personnel
  - -- Determine the status of non-active duty beneficiary records

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care.

2: Significant deficiencies in the security, maintenance, storage, or management of dental records existed. Program outcomes may be adversely affected.

1: Few criteria met. Dental records were poorly managed and/or annual inventory of dental records had not been accomplished and adverse mission impact was likely to occur.

0: The unit failed to meet the minimum provisions of the element. There was no control or inventory of dental records and/or adverse mission impact occurred or was highly likely to occur.

NA: Not scored.

Protocol

Dental Protocol 5 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty dental inspector.

Reference(s)

AFI 47-101; AFI 41-210

Element IG.2.2.10 (formerly OPS.8.4.4)

Dental Management

Evaluation Criteria

- Budgeting for dental activities was ongoing
  - -- The dental budget was annually forwarded to the medical resource management office
  - -- Education budget was in line with local, established goals and objectives and distinguished from administrative TDY requirements
- Necessary documentation existed to establish policies/procedures and provide for continuity of leadership
  - -- Dental Operating Instructions (DOIs) were in accordance with AFI 47-101 and local policies
  - -- A strategic plan existed which addressed the needs of the patient population and the strategies of the dental service to meet them
  - -- Meeting minutes of the dental leadership body provided a clear record of pertinent issues and evidence of problem resolution tracked to completion
  - -- Dental leadership periodically assessed the delivery of services via an active self-inspection program
- DoD Dental Customer Satisfaction reports were utilized by dental management as a tool to assess/improve customer service
- The benefits of membership in professional organizations were periodically briefed to the staff
- The dental service actively provided base support to ARC and individual mobilization augmentees (IMA) as authorized
- An active peer review program (Clinical Performance Assessment and Improvement) existed and was managed in accordance with AFI 47-101, applicable guidelines and policy letters

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care.

2: Cost effectiveness of dental care had not been evaluated, or funds for continuing education were not equitably distributed. Strategic planning and/or self-inspection programs were not fully developed. Program outcomes may be adversely affected.

1: Few criteria met. Inadequate implementation of the dental service budget, strategic planning, or self-inspection had the potential for an adverse impact on patient care or mission accomplishment.

0: Criteria not met. The unit failed to meet the minimum provisions of the element. Inadequate management of the dental service had an adverse mission impact.

NA: Not scored.

Protocol Dental Protocol 6 is the pertinent protocol for this element.

Inspector Contact For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty dental inspector.

Reference(s) AFI 47-101

Element IG.2.2.11 (formerly OPS.8.3.3)

Dental Products and Facility Coordination

Evaluation Criteria

- Materials and equipment in use were adequate for accomplishment of the dental mission
- The dental supply function was responsive to the needs of providers
- There was evidence that investment equipment purchases were coordinated with the USAF Dental Investigation Service (DIS)
  - -- Recently purchased products were not on the "Unacceptable" list, as published in Dental Items of Significance
  - -- Investment equipment and products that require integration with other systems were reviewed by DIS prior to purchase
- There was a current library of DIS literature
  - -- Material and equipment alerts were reviewed and acted upon
- There was evidence that dental staff members had adequate opportunity to review DIS publications. For purchase of minor equipment, DIS publications were consulted
- Dental personnel were knowledgeable about proper procedures for reporting defective or ineffective equipment and materials
- Dental facility modification (major and minor construction projects) proposals were evaluated by DIS
- The dental treatment room inventory was accurate

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care.

2: The dental supply function was not consistently responsive to provider needs. Procurement of unacceptable equipment and/or dental materials, or failure to properly report defective equipment or materials may have negatively impacted mission success.

1: Few criteria met. Procurement of unacceptable equipment and/or dental materials, or failure to properly report defective equipment or materials had the potential to result in adverse patient outcomes. Failure to coordinate facility design issues with DIS negatively impacted mission support.

0: Criteria not met. The unit failed to meet the minimum provisions of the element. The dental logistics section failed to provide necessary materials or equipment to support the dental mission. Failure to coordinate facility design issues had a profound negative impact on mission accomplishment.

Adverse mission impact and/or compromise of patient care occurred or were highly likely to occur.

NA: Not scored.

Protocol	Dental Protocol 4 is the pertinent protocol for this element.
Inspector Contact	For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty dental inspector.
Reference(s)	AFI 47-101; AFMAN 23-110, Vol 5

Area IG.2.3 Life Skills

Element IG.2.3.1 (formerly OPS.7.1.1, OPS.7.1.3, OPS.7.1.4)

Life Skills Support Center (LSSC) Leadership: Safety, Risk Management, Confidentiality, Military Law and Commander Directed Evaluations (CDE)

Evaluation Criteria

Patient and Staff Safety:

- A comprehensive plan addressed safety in patient care areas:
  - -- Plans were coordinated with the medical unit's safety plan
  - -- The plan included a request to security forces (SF) for a crime prevention/physical protection survey
- A procedure existed to notify SF in the event an individual posed immediate threat to self or others (ideally a panic button/duress alarm system)
  - -- IAW FAP Standard A-10, FA had an internal/external duress system
  - -- Evacuation plan included accountability for all persons in the building(s)
  - -- Staff described how to initiate safety/evacuation plan
- IAW FAP Standard A-14.2, plan addressed FAP Home Visit Safety Mechanism to track high risk clients
- A procedure existed to prevent high risk clients from canceling or failing to keep appointments without speaking to a provider
- Providers consulted with the Staff Judge Advocate office and/or medical law consultants on pertinent cases
- LSSC Information Sheet was signed and dated by the client and was present in each record (IAW AFI 44-109, Atch 2)
- Signed releases of information were obtained as required
- Active duty records documented client's referral status (e.g., voluntary or directed) and proper procedures were followed
- Reported nonfatal, self-injurious events using the Suicide Event Surveillance System (SESS)

Limited Privilege Suicide Prevention (LPSP):

- Providers understood when the LPSP program's protections began/ended
  - -- Plan was in place to ensure that material was protected from release
  - -- Providers educated commanders on LPSP and the limits of confidentiality Commander Directed Evaluations (CDE)
- Relevant DoD and AF instructions were utilized for CDEs; emergency CDEs were conducted by properly credentialed providers
- Commanders were required to consult with a provider prior to referral
- Providers determined legitimacy of CDE referrals
- Member's rights and due process were ensured
  - -- Written notice of the evaluation (to include appointment time, description of the reasons for the referral, name of provider consulted and a signed copy of the member's rights)

-- Member was afforded the opportunity to consult with legal counsel, inspector general or congressional representative
-- Member was provided at least two working days between notice and appointment (except for emergency evaluations)
-- Member informed of evaluation results and documented in LSSC record
- Commanders had received written CDE results as soon as possible following completed evaluations

---

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care.

2: Some, but not all criteria met. Program outcomes may be adversely affected. For example:
- A locally developed patient information sheet was used, but it was missing one of the key elements

1: Few criteria met. Adverse outcomes were expected to occur. For example:
- Patients were given only verbal information about the limits of confidentiality
- Mental health providers knew of the LPSP and Military Rules of Evidence programs but could not demonstrate knowledge of how these would be implemented in their clinic
- Commanders did not consult with a provider prior to CDE referral; proper CDE procedures not followed

0: The medical unit failed to meet the minimum provisions of the element. Adverse outcomes occurred or were highly likely to occur. For example, release was made of material protected under LPSP.

NA**:** Not scored.

Protocol

Behavioral Health Protocol 1 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty behavioral health inspector.

Reference(s)

AFI 41-201; AFI 31-101; AFI 31-201; AFI 44-154, USAF Family Advocacy Program Standards, Oct 02; AFI 44-102; AFI 44-109; DoDI 6490.4; DoDD 6490.1

Element IG.2.3.2 (formerly OPS.7.3.1)

Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program

Evaluation Criteria

- The installation commander ensured allocation of adequate space and funding for outreach and education
- Medical treatment facility commander appointed the ADAPT program manager (credentialed provider)
  - -- Established a referral process for detoxification and inpatient treatment
- The ADAPT program manager:
  - -- Kept installation commander aware of available programs through the Integrated Delivery System (IDS)/Community Action Information Board (CAIB)
  - -- Ensured annual training was conducted for health care professionals
  - -- Ensured civilian employee's assessment/treatment was IAW AFI 36-810
  - -- Collected outcome metrics on aftercare patients to assess drinking and duty performance at 3, 6 and 12-month intervals
  - -- Ensured data entered into Alcohol/Drug Abuse Data System (ADADS)
  - -- Observed certified alcohol and drug abuse counselors (CADAC) providing individual/group treatment two hours monthly
    - --- Assessed CADAC competency twice monthly
    - --- Documented observations in the CADAC training record
    - --- Ensured CADAC(s) received formal training to maintain certification, functioned in all areas of patient care and were supervised by a privileged provider
- Assessment/treatment of substance abuse patients:
  - -- Air Force members were made aware of limited protection when voluntarily disclosing evidence of personal drug use/possession
  - -- All referrals received a minimum of six hours of awareness education
  - -- A treatment team meeting was held for active duty members diagnosed with an alcohol use disorder
  - -- S-4T profile and referral for HIV testing was accomplished on all individuals diagnosed with an alcohol use disorder
  - -- S-4T profiles were reviewed monthly
  - -- Relevant Joint Commission on Accreditation of Healthcare Organizations standards apply (CAMBHC for outpatient facilities; CAMH for inpatient facilities)

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care.

2: Some, but not all criteria met. Program outcomes may be adversely affected. For example, outcome assessments were not done at specified intervals.

1: Few criteria met. Adverse mission impact was expected to occur. For example:

- Reviews of S-4T profiles were not being conducted
- Lack of oversight by the installation/MTF commanders
- Treatment team meetings did not always include commanders
- Clinical observation of CADACs was not documented

0: The medical unit failed to meet the minimum provisions of the element. Adverse mission impact occurred or was likely to occur.

NA**:** Not scored.

Protocol

Behavioral Health Protocol 1 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty behavioral health inspector.

Reference(s)

AFI 44-121; AFI 44-119; AFI 41-210; AFI 44-102; AFI 36-810; American Society of Addiction Medicine Patient Placement Criteria, Second Edition; JCAHO Comprehensive Accreditation Manual for Behavioral Health Care and Comprehensive Accreditation Manual for Hospitals, 2003

Element IG.2.3.3 (formerly OPS.7.2.1)

Family Advocacy Oversight

Evaluation Criteria

- The installation commander:
  - -- Established a Family Advocacy Committee (FAC) and appointed MDG/CC or CD as chairperson
  - -- Served as FAC member or delegated responsibility to senior staff
- FAC provided oversight for Family Advocacy Programs (FAP) and services
  - -- FAC appointments were made IAW applicable directives
  - -- Met at least quarterly and attendance constituted a quorum
  - -- Trained annually on mission and responsibilities
  - -- Ensured accomplishment of required annual training of key personnel
  - -- Set installation FAP policy
  - -- Ensured needed MOUs were in place and reviewed every 24 months
  - -- Reviewed/approved the FAP action plan annually
  - -- Reviewed metrics to implement needed programs
  - -- Appointed FAC member and alternate to review requests for Incident Status Determinations Review (ISDR)
  - -- Appointed High Risk for Violence Response Team (HRVRT) members IAW FAP Standard M-3
    - --- Family Advocacy Officer reported HRVRT activities quarterly and ensured these were documented in FAC minutes
  - -- Appointed Child Sexual Maltreatment Response Team (CSMRT) members IAW FAP Standard M-2
  - -- CSMRT trained annually on roles and responsibilities

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care.

2: Some, but not all criteria met. Program outcomes may be adversely affected. For example, annual training of FAC members on responsibilities and FAP mission had not been accomplished.

1: Few criteria met. Adverse program outcomes were expected to occur. In essence, the FAC was only minimally involved and may not have had a clear picture of what the FAP was doing. For example:

- The FAC was not meeting as often as required
- The FAC provided little oversight to the FAP

0: The medical unit failed to meet the minimum provisions of the element. Adverse program outcomes occurred or were highly likely to occur.

	NA**:** Not scored.
Protocol	Behavioral Health Protocol 1 is the pertinent protocol for this element.
Inspector Contact	For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty behavioral health inspector.
Reference(s)	AFI 40-301; AFI 90-501; USAF Family Advocacy Program Standards, Oct 02

Element IG.2.3.4 (formerly OPS.7.2.2)

Family Maltreatment Case Management Team (FMCMT)

Evaluation Criteria

- The FMCMT met monthly and was chaired by the Family Advocacy Officer (FAO)
  - -- If spouse and child meetings were held separately, each met monthly
  - -- Child protective services (CPS) and domestic violence shelter representatives were invited as non-voting guests
- FMCMT membership was IAW FAP Standard M-1
  - -- A quorum was present for case status determinations
- Squadron commanders and first sergeants were invited as non-voting guests
- Open physical and emotional maltreatment cases were reviewed quarterly
- Open child sexual maltreatment cases were reviewed monthly
- Minutes reflected incident status determinations, intervention plans and status (open, closed, transferred)
- CSMRT/HRVRT decisions and plans were reported at each FMCMT
- Family Advocacy System of Records (FASOR)-generated documentation was filed in each family member's outpatient record
- FMCMT minutes were identified and handled IAW FAP Standard M-1

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care.

2: Some, but not all criteria were met. Program outcomes may be adversely affected. For example, labeling of incident status determinations was not consistent with FAP Standards.

1: Few criteria met. Adverse program outcomes were expected to occur. For example:

- A quorum was not always present
- Cases were not reviewed as often as required
- HRVRT activities were not reported to the FMCMT

0: The medical unit failed to meet the minimum provisions of the element. Adverse program outcomes occurred or were highly likely to occur.

NA**:** Not scored.

Protocol

Behavioral Health Protocol 1 is the pertinent protocol for this element.

Inspector Contact	For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty behavioral health inspector.
Reference(s)	AFI 40-301; USAF Family Advocacy Program Standards, Oct 02

Element IG.2.3.5 (formerly OPS.7.2.5 and OPS.7.2.6)

Assessment and Care of Family Maltreatment Clients

Evaluation Criteria

Assessment:

- Initial assessment occurred within 3 duty days of referral
  - -- Assessment addressed all relevant components IAW FAP Standard M-11
  - -- Referrals made/consultations obtained when indicated
  - -- High Risk for Violence Response Team (HRVRT) met at call of Family Advocacy Officer (FAO) when indicated IAW FAP Standard M-3
  - -- Child Sexual Maltreatment Response Team (CSMRT) met upon child sexual maltreatment referrals; activation/non-activation decision process was documented in the FAP record

Care:

- A signed statement of informed consent was obtained (legal guardian as needed)
  - -- The FAO consulted with Staff Judge Advocate on requests for information
  - -- Intervention plans noted measurable goals
  - -- Each client contact was documented in the FAP and outpatient records (and the LSSC record if appropriate)
- Each entry was dated and signed by a provider
- Termination notes were completed IAW FAP Standard A-17

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care.

2: Some, but not all criteria met. Program outcomes may be adversely affected. For example, assessment processes were not standardized among providers.

1: Few criteria met. Increased risk of client harm was expected to occur. For example:

- Assessments were not done within 3 duty days
- CSMRT activation decisions were not documented
- There was an excessive time lapse between initial report and the activation decision

0: The medical unit failed to meet the minimum provisions of the element. Increased risk of client harm occurred or was highly likely to occur.

NA**:** Not scored.

Protocol	Behavioral Health Protocol 1 is the pertinent protocol for this element.
Inspector Contact	For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty behavioral health inspector.
Reference(s)	AFI 40-301; USAF Family Advocacy Program Standards, Oct 02

Element IG.2.3.6 (formerly OPS.7.2.9)

New Parent Support Program

Evaluation Criteria

- The Family Advocacy Nurse (FAN) was responsible for implementation and management of the New Parent Support Program (NPSP)
- The FAN provided home-based services to prevent child and spouse maltreatment IAW FAP Standard P-10
  - -- Each record contained the documentation outlined in FAP Standard P-14
    - --- Signed statements of informed consent were obtained from each adult prior to enrollment
- The team staffing meeting had reviewed all high-needs families within 45 days of the first home visit
  - -- All families who received a home visit were staffed within 45 days
  - -- Case staffings were documented on the family's case staffing form and SF 600 for the outpatient medical record, when needed
  - -- Where a full FAP core team exists, evidence of Family Advocacy Treatment Manager (FATM) involvement was documented in NPSP records (FATM home visits or office consultation)

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care.

2: Some, but not all criteria met. Program outcomes may be adversely affected. For example, the NPSP did not include all four of the prescribed key model components.

1: Few criteria met. Adverse program outcomes were expected to occur. For example, enrolled families were not consistently staffed within 45 days of the first home visit.

0: The medical unit failed to meet the minimum provisions of the element. Adverse program outcomes occurred or were highly likely to occur.

NA**:** Not scored.

Protocol

Behavioral Health Protocol 1 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty behavioral health inspector.

Reference(s) AFI 44-301; USAF Family Advocacy Program Standards, Oct 02; NPSP Program Manual, 1999

Area IG.2.4 Population Health

Element IG.2.4.1 (formerly LED.2.2.2, OPS.5.2.1, OPS.6.1.1 and OPS.6.1.2)

Population Health Structure and Process (PHSP)

Evaluation Criteria

Population Health Assessment and Program Evaluation Functions:

- Sound epidemiological principles were applied to evaluate population health assessment results and health promotion (HP) program processes
  - -- Community needs assessment survey and IDS survey results are used to assess population health
- Assessment results and trend reports were used to design required Air Force health promotion programs and establish goals and objectives which were consistent with Air Force Medical Service/MAJCOM/local goals
- Protocols, supporting self-reported HRA data, identified responses requiring further evaluation, and those requiring further intervention were properly referred
- A process was in place to apprise senior leaders (squadron, group, wing) of the health of the population (fitness levels, tobacco use, preventive health assessment status, ergometry data, etc.)

Population Health Administration and Oversight:

- Oversight for population health and prevention was clearly defined (e.g., population health workgroup/function/committee or similar group as designated by the medical treatment facility executive leadership)
  - -- Membership included representatives as recommended in AFPAM 44-155 and others with population health roles such as the Health Care Integrator and Group Practice Manager
- The oversight group was involved in continual assessment and refinement of population health initiatives (e.g., evaluation and implementation of new or changing population health recommendations and development of local population health protocols)
  - -- The group ensured optimal integration of health-oriented groups, processes and personnel, e.g., HAWC, PHA, TRICARE, volunteer groups and civilian agencies (Red Cross, American Heart Association, American Cancer Society, etc.)
  - -- The group considered communicable disease patterns, occupational illness/injury trends and environmental conditions in developing prevention and intervention strategies
  - -- Periodic demographic analysis was accomplished and the results used to target resources and identify unique population needs
  - -- The group identified proper measures of performance (both process and outcome oriented) which were gathered, tracked, analyzed & acted upon

-- The group coordinated local efforts with their lead agent and MAJCOM
- The oversight group received comprehensive support from the medical group commander, executive leadership and information systems
  -- Adequate resources were available for population health activities including funding, personnel, space and equipment

Evaluation Criteria

Health Promotion Program:

The wing commander:
- Allocated sufficient appropriated funding and staffing resources to support effective Health and Wellness Center (HAWC) operations
- Reviewed metric data prior to submission to major command
- Chaired (or designated an alternate to chair) the health promotion working group (HPWG)
- The HPWG (meeting at least quarterly) developed a focused, integrated and comprehensive installation health promotion program (HPP)
- In conjunction with the MDG/CC, ensured adequate and qualified staff were assigned to the HAWC

Medical Group Commander (MDG/CC):
- Allocated sufficient Defense Health Program (DHP) funding to support effective HPP operations
- In conjunction with the Installation Commander, ensured adequate and qualified staff were assigned to the HAWC [Staffing as a minimum: one HPM, one medical technician (two if base total force population greater than 6,000), one exercise physiologist, and one information manager]

Evaluation Criteria

Population Health Training, Education and Marketing:
- Focused skills training (both initial and recurring) was developed and targeted to primary care managers, nurses, technicians, clerical staff, medical records personnel, volunteers and any other medical personnel working with enrolled beneficiaries. For example:
  -- Population health concepts were incorporated into the basic curricula in facilities that have provider, nursing, technician, and ancillary health training programs
  -- Primary care residency programs provided ongoing, integrated training in population health
  -- Provided general training to incoming medical treatment facility personnel regarding population health and any locally pertinent information (e.g., local age/gender data regarding tobacco use, recreational drug use, and alcohol-related issues)
- Population health education for patients was accomplished in diverse forums, which might include informational handouts and video presentations in waiting areas, articles in base and local newspapers, presentations at various installation and community meetings, radio and television spots, newcomers' orientation and through referrals to health educators

- Results of documentation monitoring and evaluation protocols were given to providers and forwarded to their individual professional activities files
  -- Results of monitoring analysis were further aggregated to clinical and medical treatment facility levels. This information was fully integrated with the unit peer review and performance improvement programs

---

Scoring

4: Criteria met.

3: Considerable population health outcomes are demonstrated. However, minor deficiencies were noted and unlikely to significantly hamper population health progress.

2: Although population health efforts are visible, some, but not all non-administrative criteria were met. Population health efforts may be hampered by inadequate resources, failure to focus on population health priorities, or lack of integration of population health activities.

1: Minimal compliance with evaluation criteria had potential negative impact on population health improvement. Adverse mission impact was likely to occur due to items such as:
- Lack of executive leadership support of population health improvement
- Resource allocations to population health were inadequate a policy for individualized review of customer assessment responses.
- Lack of epidemiological data analysis and application in the program planning and evaluation processes
- Lack of metrics or other data based tools used for decision making

0: The unit failed to meet the minimum provisions of the element.

NA: Not scored.

Protocol

Nurse Protocol 1 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty nurse inspector.

Reference(s)

AFPD 40-1; AFI 40-101; AFPAM 44-155; AFI 44-102; AFI 48-105; ASD(HA) memorandum 98-027, Put Prevention Into Practice (PPIP) Policy, 31 Mar 98; HQ USAF/SG memorandum, Implementation of PPIP Within Air Force MTFs, 24 Jul 95

Element IG.2.4.2 (formerly LED.2.2.3 and OPS.5.2.2)

Primary Care Optimization (PCO) Clinical Management

Evaluation Criteria

- A clearly identified leadership body was responsible for oversight of population health activities implemented by the PCO team, e.g., population health committee. This group:
  - -- Identified education and training needs for the medical staff, which included training in population health, the Preventive Health Assessment (PHA), and occupational medicine issues
  - -- Developed a strategy to implement population health activities throughout the PCO teams which addressed the AFMS population health critical success factors:
    - --- Identify the enrolled population's needs and health status
    - --- Forecast and manage demand and capacity
    - --- Proactively deliver preventive services
    - --- Manage medical and disease conditions
    - --- Evaluate improvement in the population's health status and the delivery system's effectiveness and efficiency
    - --- Energize a community approach to population health outreach
    - --- Analyze performance and health status
  - -- Planned and prioritized population health activities based upon population health data and priorities set forth by leadership
  - -- Ensured adequate resources (personnel, budget, training, etc.)
  - -- Monitored appropriate measures of performance (both process and outcome) for compliance with regulatory or locally established standards (e.g., timeliness of referrals to PCM given significant responses on the health history questionnaire)
- PHAs were accomplished by the PCO team
- Preventive care portions of the preventive care flowsheets (e.g., DD Form 2766 and AF Form 1480/3923) for all beneficiaries were consistently completed
- Tracking systems were in place to ensure indicated testing and/or counseling was accomplished
- Age/gender appropriate risk reduction counseling, risk assessments, recommended screening tests and immunizations/chemoprophylaxis recommendations were made in accordance with accepted prevention guidelines found in TRICARE Prime enhanced benefits package, US Preventive Task Force publications, or higher USAF directives, whichever is more stringent
- Counseling was documented on preventive care flowsheets (DD Form 2766, AF Form 1480A, AF Form 3922/3923, SF 600, SF 88, PHA documents)
- The client's understanding of provided data and acceptance or declination of offered services was documented

- There is at least one outpatient oriented evidence-based clinical practice guideline in use in the primary care arena
- Incorporation of the guideline into clinical practice was based on evaluation of the needs of the enrolled population
- Locally selected outcome measures were monitored for progress toward desired goals (e.g., compliance with mammogram screening recommendations)

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to hamper population health improvement efforts. Less than 90 percent of the DD Forms 2766 (or AF Forms 1480A/3922/3923) were accurate and appropriate.

2: Not all criteria met. Population health efforts may be hampered by failure to perform or document appropriate testing and counseling. For example:
- Less than 80 percent of the DD Forms 2766 (or AF Forms 1480A/3922/3923) were accurate and appropriate
- A significant number of medical records did not show evidence of appropriate counseling or recommended interventions
- Beneficiaries were not provided with appropriate preventive services

1: Adverse mission impact was likely to occur. For example:
- Less than 60 percent of DD Forms 2766 (or AF Forms 1480A/3922/3923) were accurate and appropriate
- Numerous medical records lacked evidence of appropriate counseling or recommended interventions

0: The medical unit failed to meet the minimum provisions of the element. Adverse mission impact, such as a medically unprepared deployment force, was highly likely to occur.

NA: Not scored.

Protocol

Nurse Protocol 1 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty nurse or physician (flight surgeon) inspector.

Reference(s) AFPAM 44-155; HQ USAF/SG memorandum, Implementation of Putting Prevention Into Practice (PPIP) Within Air Force Medical Treatment Facilities, 24 Jul 95; HQ USAF/SG memorandum, Guidelines for the Implementation of Preventive Health Assessment and Individual Medical Readiness (PIMR) at Air Force Medical Treatment Facilities, 28 Dec 01; PCO Implementation Guide; DoD Population Health Improvement Plan and Guide, Dec 01

Element IG.2.4.3 (formerly OPS.7.1.5 and OPS.7.2.8)

Life Skills Support Center and Community Prevention

Evaluation Criteria

Suicide and Violence Prevention:

- A plan existed ensuring all military members and civilian employees received annual training in suicide prevention/violence awareness education
  - -- The plan was based on the calendar year
  - -- The training covered topics IAW AFI 44-154 Attachments 2 and 3
    - --- The Life Skills Support Center (LSSC) as the POC, collaborated with the Integrated Delivery System (IDS) to identify training instructors
    - --- Reported training metrics quarterly IAW AFI 44-154 Attachment 4
- LSSC reported nonfatal self-injurious events using the Suicide Event Surveillance System (SESS)

Community Prevention of Substance Abuse:

- Substance Abuse prevention services were a collaborative effort within the IDS and included LSSC and the Health and Wellness Center (HAWC)
  - -- The Demand Reduction Program Manager (DRPM) was the focal point for the goal of a drug-free community and participated in the Community Action Information board (CAIB)/IDS/community coalitions, to coordinate outreach and education initiatives
    - --- DRPMs ensured proper expenditure of funds for outreach activities
    - --- Ensured the non-active duty population (family members, retirees and school age children) received substance abuse prevention and education IAW AFI 44-159 (section C-3)
  - -- The ADAPT Program Manager collaborated with the CAIB/IDS
    - --- Ensured ADAPT substance abuse prevention efforts were conducted IAW AFI 44-121

Preventing Family Violence:

- The Family Advocacy Outreach Manager (FAOM) was the FAP representative to the IDS and was actively involved with base and civilian agencies that promoted healthy families and enhanced community cohesion. The FAOM:
  - -- Marketed and briefed FAP IAW FAP Standards P-6 and 7
  - -- Developed/delivered FAP prevention services in collaboration with IDS
    - --- Principal FAP liaison to IDS for New Parent Support Program (NPSP)
  - -- Ensured that program activities meet FAP Standard P-8
- The FAOM contributed to the development of the annual community needs assessment and the biannual community action plan
  - -- The FAOM facilitated development of the annual FAP action plan IAW FA Standard P-5
    - --- FAP action plan was approved by the FAC/CAIB annually
    - --- Documentation of the above activities were referenced in the FAC minutes
    - --- Outreach activities were documented IAW FAP Standard P-13

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise mission support.

2: Some, but not all criteria met. Program outcomes may be adversely affected. For example:
- Members did not attend CAIB/IDS meetings or involvement was minimal
- Funds for prevention/outreach activities were not spent as authorized

1: Few criteria met. Adverse programs were expected to occur. For example:
- The absence of required prevention programs
- Suicide and violence awareness and education briefings were not conducted or no plan existed

0: The medical unit failed to meet the minimum provisions of the element. Adverse program outcomes occurred or were highly likely to occur. For example, there was no community prevention effort.

NA**:** Not scored.

Protocol

Behavioral Health Protocol 2 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty behavioral health inspector.

Reference(s)

AFI 44-120; AFI 44-121; AFI-44-159; AFI 40-301; AFI 44-153; AFI 44-154; AFI 90-501; AFPAM 44-160; USAF Family Advocacy Program Standards, Oct 02

Element IG.2.4.4 (formerly OPS.6.2.1, OPS.6.2.2, OPS.6.2.3, OPS.6.2.6 and OPS.6.2.7)

Health and Wellness Programs:

Evaluation Criteria

Health Promotion Program:

- The wing commander:
  - -- Allocated sufficient appropriated funding and staffing resources to support effective Health and Wellness Center (HAWC) operations
  - -- Reviewed metric data prior to submission to major command
  - -- Chairs (or designated an alternate to chair) the health promotion working group (HPWG)
  - -- The HPWG (meeting at least quarterly) developed a focused, integrated and comprehensive installation health promotion program (HPP)
  - -- In conjunction with the MDG/CC, ensured adequate and qualified staff were assigned to the HAWC

- Medical Group Commander (MDG/CC):
  - -- Allocated sufficient Defense Health Program (DHP) funding to support effective HPP operations
  - -- In conjunction with the Installation Commander, ensured adequate and qualified staff was assigned to the HAWC. Staffing included (at minimum) one HPM, one medical technician (two if base total force population greater than 6,000), one exercise physiologist, and one information manager

- The Health Promotion Manager:
  - -- Managed, planned (including budget development) and conducted the installation Health Promotion Program (HPP)
  - -- Provided tailored marketing and communication functions, lifestyle modification and support programs
  - -- Reviewed and forwarded metric data, as defined in AFPD 40-1
  - -- Provided HPP activity and outcome-based data to the aerospace medicine team and the HPWG, which served as a basis for establishing disease prevention and health promotion priorities
  - -- Served as co-chairperson of the HPWG
  - -- Actively participated in the Integrated Delivery System (IDS) and the MTF population health workgroup/function/committee
  - -- Established liaison with supporting installation medical personnel and other community agencies to ensure an integrated disease prevention and health promotion program [consider the Community Action Information Board (CAIB) as a mechanism to contribute at the wing level]

1. Alcohol and Substance Abuse Prevention

Evaluation Criteria

- Health promotion personnel supported alcohol and substance abuse prevention awareness and education programs
- Health promotion, mental health and substance abuse personnel identified and utilized referral agencies and prevention programs, both on and off base
- Health promotion and substance abuse personnel worked cooperatively to ensure sound education and prevention/awareness programs and initiatives were integrated into the community through a variety of modalities and agencies

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to impede the alcohol and substance abuse prevention efforts.

2: Although the basic mission was accomplished, program education and awareness programs were not fully integrated. There was no impact on the program.

1: Base-supported opportunities to participate in alcohol and substance abuse prevention activities were limited and/or cooperation between health promotion and substance abuse personnel was not effective.

0: There was no evidence of an integrated approach to program execution. The health promotion personnel did not support the alcohol and substance abuse prevention awareness and education programs. The program failed to identify and utilize available referral agencies. The program did not support basic mission requirements.

NA**:** Not scored.

Reference(s)

AFPD 40-1; AFI 40-101; 1998 USAF Program Action Directive 96-05, Annex E

2. Stress Management

Evaluation Criteria

- Stress management was emphasized at all organizational levels (e.g., commanders, supervisors and subordinates) regarding organizational and environmental stressors and their impact on health
- Programs to identify, manage and reduce stress were offered by personnel trained in stress management
- Expert review of stress management programs was conducted by a qualified person trained in behavioral health

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to impede stress management program efforts.

2: Although the basic mission was accomplished, there was no evidence that all organizational levels received emphasis on environmental stressors. The potential for missed preventive intervention opportunities existed.

1. There was no evidence that qualified behavioral health experts reviewed all base stress management programs. Stress management programs were not available to all organizational levels. Lack of oversight potentially impeded efforts to identify, manage and reduce stress.

0: The program did not support basic mission requirements. For example there were no efforts to identify, manage and reduce stress within the community population. Base-supported opportunities to participate in stress management activities did not exist.

NA**:** Not scored.

Reference(s) AFPD 40-1; AFI 40-101

3. Tobacco Use Cessation and Prevention

Evaluation Criteria

- Tobacco use cessation/prevention interventions were offered for military and civilians at least quarterly, during and after duty hours
- Tobacco cessation interventions were offered to geographically separated personnel (AFIT, AFROTC, recruiters etc.)
- Personnel providing formal tobacco cessation classes were appropriately trained
  -- Programs were developed to discourage initial tobacco use
- Pharmacotherapy was available whenever possible
- Follow-up survey of "quitters" was conducted at the 6 month post-quit point to measure program (outcome) success

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to impede the tobacco use or cessation program.

2: There was only partial compliance with evaluation criteria. Although the basic mission was accomplished, the potential for missed preventive intervention opportunities existed.

1: Failure to properly execute the program adversely impacted mission accomplishment. For example:
- Base-supported opportunities to participate in tobacco use and cessation programs were limited.
- Smoking cessation courses were taught by personnel with no formal program training.

0: There was no evidence of an integrated approach to program execution. The program did not support basic mission requirements. For example:
- No pharmacotherapy available for program participants.
- No opportunities for tobacco cessation offered to geographically separated personnel.
- No follow-up survey of "quitters" conducted or reported to the prevention planning team.

NA**:** Not scored.

Reference(s)

AFPD 40-1; AFI 40-101; AFI 40-102; HQ USAF/SG Memorandum, Smoking Cessation Help for Geographically Separated Personnel, 8 Jun 94

4. Nutrition Education

Evaluation Criteria

- Nutrition education was integrated into other lifestyle modification programs (for example, substance abuse, tobacco cessation, preventive health assessments) where appropriate
- The major command consultant dietitian certified nutrition counselors to perform nutrition counseling
- Nutritional counselors provided location-specific training when necessary to accomplish local mission

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to impede the nutrition education program.

2: Although the basic mission was accomplished, base-supported opportunities to participate in nutrition education activities were limited. There was a potential for negative impact on the nutrition education program.

1: Failure to properly execute the nutrition education program adversely impacted mission accomplishment. There was no evidence of integration of nutrition education into health promotion efforts such as substance abuse, preventive health assessments or tobacco cessation. Opportunities for effective intervention were missed.

0: There was noncompliance with multiple evaluation criteria or the program failed to support the basic mission requirements. For example:

- Opportunities to participate in nutrition education activities did not exist
- There was no evidence of expert dietary consultation or program oversight
- There was no integration of nutrition education in the health promotion activities base-wide
- The nutrition education program management team failed to provide education or training to installation services upon their request

NA**:** Not scored.

Reference(s) AFPD 40-1; AFI 40-101; AFI 40-104; AFI 40-502; AFI 44-102; AFI 44-135; AFMAN 44-135; AFPAM 44-132

5. Cardiovascular Disease, Cancer & Other Preventive Efforts

Evaluation Criteria

- Strategies were based on established priorities, e.g., needs assessment, health enrollment assessment review data or other Air Force Medical Service approved healthcare benchmark
- The health promotion manager conducted/coordinated public information and social marketing campaigns on cardiovascular disease and cancer prevention, injury reduction and other preventive efforts (based on a health assessment)
- Efforts targeted identified "at-risk" populations

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to impede cardiovascular disease, cancer and other prevention efforts.

2: Although the basic mission was accomplished, base-supported opportunities to participate in cardiovascular disease, cancer and other prevention activities were extremely limited.

1: Failure to properly execute the program adversely impacted mission accomplishment. There were no coordinated marketing campaigns on injury reduction, as identified during health assessment data reviews. Lost work time from preventable injuries occurred.

0. Compliance with basic program requirements was not evident.

- No local strategies or program priorities were established based on health assessment data or approved healthcare benchmarks
- There was no evidence of efforts targeting identified 'at risk' populations
- The health promotion manager did not coordinate or conduct public information and social marketing campaigns on cardiovascular disease or cancer prevention activities

NA**:** Not scored.

Reference(s) AFPD 40-1; AFI 40-101

Overall Scoring

4: Criteria met in all five health and wellness programs.

3: Identified minor deficiencies in one or two programs were minor, primarily administrative in nature, and unlikely to impede prevention efforts.

2: One or two of the five health and wellness programs scored a "2." Although the basic mission was accomplished, the potential for missed preventive intervention opportunities existed.

1: Three or more of the health and wellness programs scored a "3" or lower. Prevention activities were limited, lacked appropriate oversight and improper execution of programs adversely impacted mission accomplishment.

0: There was no evidence of an integrated approach to program execution. There was noncompliance with multiple evaluation criteria and the programs failed to support the basic mission requirements.

Protocol

Nurse Protocol 3 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty nurse inspector.

Reference(s)

As previously annotated in sub-sections of this element.

Element IG.2.4.5 (formerly OPS.5.1.1 and OPS.5.1.2)

Preventive Dentistry

Evaluation Criteria

- There was an established and ongoing preventive dentistry education program based on dental population health data
- Dental personnel were knowledgeable of current dental population health information and techniques
  -- Dental population health data demonstrated improvement in oral health of the base population
- Patient education was evidence based and approached consistently by all members of the dental staff
- Dental personnel sponsored or participated in individual and/or group oral health counseling (e.g., prenatal classes, tobacco cessation programs, National Children's Dental Health Month activities, etc.)
- Personnel providing formal tobacco cessation classes were appropriately trained
- Local media were used as available
- Dental representation in the Population Health Committee was appropriate and dental issues were properly channeled to this committee
- An active, comprehensive preventive dentistry training program provided upgrade training, skills verification, and refresher training as needed to sustain a high quality staff
- A well established competency assessment program demonstrated a thorough, systematic evaluation of care delivered by all non-privileged providers
- Comprehensive clinical fluoride protocols were in place, and a sustained program to identify, treat, monitor, and appropriately follow patients was evident
- An athletic mouthguard program was in place, and mouthguard use was encouraged for all beneficiaries engaged in contact sports
- The skill level of the technicians was commensurate with the difficulty of the prophylaxis cases treated

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care.

2: Significant deficiencies existed in Preventive Dentistry Education, such as poorly coordinated education efforts, minimal involvement in community oral health activities, or inadequate use of local media. Significant deficiencies existed in Preventive Dentistry and Oral Prophylaxis Support. Dental prophylaxis training, competency assessment, clinical fluoride

protocols, or athletic mouthguard programs were not fully developed or implemented. Program outcomes may be adversely affected.

1: Few criteria met. Key provisions of the Preventive Dentistry Education program were lacking. There was no evidence of involvement in community oral health activities or MTF population health activities. Dental prophylaxis training, competency assessments, clinical fluoride protocols, or athletic mouthguard programs were lacking. Adverse mission impact or compromise of patient care was likely to occur.

0: Criteria not met. The unit failed to meet the minimum provisions of the element. Adverse mission impact and/or compromise of patient care occurred or were highly likely to occur.

NA: Not scored.

Protocol Dental Protocol 1 is the pertinent protocol for this element.

Inspector Contact For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty dental inspector.

Reference(s) AFI 47-101

Element IG.2.4.6 (formerly OPS.7.3.4)

Demand Reduction Program – Drug Testing

Evaluation Criteria

- Medical Treatment Facility (MTF) commander appointed a Demand Reduction Program Manager (DRPM), a Drug Testing Program Administrative Manager and a Medical Review Officer
- The Cross-Functional Oversight Committee (CFOC) met IAW AFI 44-120
- Unit commanders appointed credible observers IAW AFI 44-120
- DRPM and Staff Judge Advocate (SJA) provided periodic observer training
  - -- Documented that observers were briefed prior to each testing day
  - -- All AF members were subject to random urinalysis testing and were equally eligible for testing on each testing day
- SJA performed and documented a quarterly program assessment
- The untestable specimen rate was under one percent
  - -- When the untestable rate exceeded one percent, an action plan was developed
  - -- Members whose specimens were determined to be untestable were retested
- AF software was used (mandatory unless waiver approved by AFMOA)
- Notifications to trusted agents were made on the day of testing
  - -- Commanders were told to notify members to report within two hours
- Testing was conducted randomly at a minimum of eight days a month
- Geographically separated unit (GSU) collections were accomplished
- Members selected for testing reported within two hours of notification
  - -- Members not reporting within two hours were tracked and reported to the member's commander

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise mission support.

2: Some, but not all criteria met. Program outcomes may be adversely affected. For example:

- There was inadequate training for observers and their alternates
- Procedures for conducting GSU collections had not been developed

1: Few criteria met. Adverse program outcomes were expected to occur. For example:

- Inadequate follow-up on personnel who failed to test without a valid reason
- Drug testing was not conducted at least eight times per month
- The chain of custody was inadequate

0: The medical unit failed to meet the minimum provisions of the element. Adverse program outcomes occurred or were highly likely to occur.

NA**:** Not scored.

Protocol Behavioral Health Protocol 1 is the pertinent protocol for this element.

Inspector Contact For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty behavioral health inspector.

Reference(s) AFI 44-120; AFI 44-159

Element IG.2.4.7 (formerly OPS.7.2.7)

Special Needs Identification and Assignment Coordination Process [Exceptional Family Member Program (EFMP)]

Evaluation Criteria

- Marketing activities were conducted to enhance EFMP enrollment
- MDGI defined processes IAW FAP EFMP Standards E-1 to E-7
  - -- A referral log was maintained in chronological order with corresponding case numbers and documentation of "Q" code requests
  - -- Facility determination inquiries (FDI) were tracked
- Family Advocacy Committee/Community Action Information Board provided program oversight

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care.

2: Some, but not all criteria met. Program outcomes may be adversely affected. For example, absence of ongoing case management (e.g., cases were held open for long periods of time without knowing whether the family was still in the local area).

1: Few criteria met. Adverse program outcomes were expected to occur. For example:

- FDIs were made without sufficient information
- The relocation clearance process was not effectively managed
- Routine FDIs were not consistently answered in a timely manner

0: The medical unit failed to meet the minimum provisions of the element. Adverse program outcomes occurred or were highly likely to occur.

NA**:** Not scored.

Protocol

Behavioral Health Protocol 1 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty behavioral health inspector.

Reference(s)

AFI 40-301; AFMOA/CC memorandum, Family Member Relocation Clearance Process Revision, 24 Jul 02; USAF Family Advocacy Program EFMP Standards, Jul 98

Area IG.2.5 Clinical Services

Element IG.2.5.1. (formerly LED.2.3.4)

Professional Services Management

Evaluation Criteria

- The unit organizational plan included the office of the chief, medical staff
- The chief was a privileged physician holding an active appointment to the medical staff and appointed by the unit commander
- The chief of the medical staff:
  - -- Was the principal executive staff advisor to the unit commander concerning matters of provider regulations, quality and scope of medical care, utilization of professional resources and medical policy/planning
  - -- Was responsible for and has oversight of the credentialing and privileging process
  - -- Defined criteria and data elements to support performance-based privileging
  - -- Was chairperson of the executive committee of the medical staff and the credentials function
  - -- Acted as liaison between members of the medical staff and the unit commander advocating on behalf of the medical staff and executive management
  - -- Oriented all medical staff applicants concerning AF bylaws governing patient care, medical staff responsibilities, professional ethics, continuing medical education requirements, privileging, adverse action and due process proceedings
  - -- Established and monitored a professional clinical peer review function that defined clinical standards of care
  - -- Monitored the quality of professional services provided by privileged providers (e.g., lab/radiology studies, interpretation and follow-up, specialty referral review and follow-up)
  - -- Monitored discharge planning by overseeing utilization review process

---

Scoring

4: Criteria met.

3: Minor discrepancies, primarily administrative in nature, were unlikely to compromise mission support.

2: Some, but not all criteria met. For example, lack of appropriate intervention was noted in a significant number of abnormal laboratory findings. A significant number of consultative reports lacked documented provider review and were not present in the medical record. Appropriate reviews, depending upon the scope of care, did not occur for drug, surgical, and blood use.

1: Adverse impact on mission and patient health could be expected to occur. The medical staff failed to effectively perform required functions.

0: The medical unit failed to meet the minimum provisions of the element. Adverse mission impact occurred or was highly likely to occur. The chief was ineffective, which caused medical care to be compromised.

NA: Not scored.

Protocol

Team Chief Protocol 3 and Flight Surgeon Protocol 7 are the pertinent protocols for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty physician (flight surgeon) inspector.

References

AFMAN 36-2105; AFPD 44-1; AFI 44-102; AFI 44-119; HA Policy Memorandum 98-007, Policy For Specialty Care Consultants, 7 Jan 98; USAF/SG memorandum, Filing of Outpatient Computerized Laboratory and Radiology Reports, 28 Feb 97

Element IG.2.5.2 (formerly OPS.1.2.2)

Emergency Response: Ambulances and Equipment

Evaluation Criteria

- The ambulance service was designed to meet the needs of the base flying/special operations missions and community contingency situations
- Written protocols provided adequate guidance for emergency response
  - -- If applicable, protocols covered special equipment needs for responding to the flight line in other than flight surgeon office ambulances (e.g., using aeromedical staging facility ambulances to respond to medical emergencies in air evacuation passengers)
- Pre-hospital protocols were used and maintained in the ambulances; emergency equipment supported the complete spectrum of expected technician capabilities as described in the pre-hospital protocols
- Ambulance supplies and layout were standardized between units to the greatest extent possible
- Essential equipment/supplies were available for use, including (but not limited to):
  - -- Triage and emergency stabilization for mass casualty situations
  - -- 100 percent oxygen delivery system compatible with aviator mask
  - -- Defibrillator (automatic electronic defibrillators, if authorized by the medical unit for use in the field)
  - -- Maps of base and local community
  - -- Disaster response checklists
  - -- Two-way voice communications with medical unit/fire-crash personnel
  - -- Personal protective equipment (PPE) for blood and body fluid protection
  - -- Appropriate PPE for hazardous material incident responses (e.g., radioactive materials, hydrazine, etc.)
- All non-flight medicine personnel who may respond to the flight line (e.g., emergency room/acute care clinic or civilian ambulance personnel after normal duty hours):
  - -- Had been trained in the proper procedures for flight line response to the same level as flight medicine personnel
  - -- Had flight line driving privileges and line badges (if required by the installation)
  - -- Were familiar with flight surgeon office ambulances, if used to respond
  - -- Had all appropriate checklists, written guidance and necessary equipment for covering flight line responses in all responding vehicles

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care.

2: Some, but not all criteria met. Emergency response could have been sub-optimal with possible adverse mission impact due to missing or outdated supplies, or inadequate training of emergency response personnel.

1: Adverse mission impact, such as unnecessary morbidity/mortality, was highly likely to occur. Examples:
- Critical equipment/supplies were inadequately maintained
- Ambulances or ambulance services did not completely meet operational community needs

0: The medical unit failed to meet the minimum provisions of the element. Adverse mission impact, such as unnecessary morbidity/mortality, occurred. Examples:
- Critical equipment/supplies were missing, outdated or nonfunctional
- Ambulances or ambulance services clearly did not meet operational community needs

NA**:** Not scored.

Protocol Senior Enlisted Protocol 6 is the pertinent protocol for this element.

Inspector Contact For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty senior enlisted inspector.

Reference(s) AFI 44-102; AFI 44-318; AFI 444-119; AFI 24-301

Element IG.2.5.3 (formerly HCS.1.3.3)

Health Records Availability and Management

Evaluation Criteria

- The MTF followed local procedures which had been established to:
  - -- Ensure that records contain accurate and complete documentation of outpatient visits
  - -- Inventory active duty records annually by 31 March with a goal of completing follow-up within 30 days
  - -- Limit access to all outpatient records areas
  - -- Fully use the CHCS Medical Record Tracking module to track movement of the outpatient records
  - -- Require consistent use of charge out guides and accurate, complete information on AF Forms 250
  - -- Implement a system for delivery of records to clinics for scheduled appointments and walk-ins
  - -- Specify time criteria for records return and follow-up actions to retrieve delinquent records
  - -- Ensure 90 percent availability and accountability (as defined by Air Staff policy) of outpatient records by establishing local tracking and retrieval procedures which include, at minimum:
    - --- A monthly review of charged out records and a methodology to retrieve those records charged out
    - --- A mechanism to regain custody of those outpatient records which are being maintained by the patient
    - --- Education of staff and patients on the importance and reasons why records must be maintained by the MTF
  - -- Use the CHCS Overdue Records List report, or other like method, to determine accountability for each records room and aggregated for the overall MTF average
    - --- Maintain daily statistics and compute monthly average for each records room and aggregate for the overall MTF average
    - --- Report monthly availability and accountability rates through the records review function at the MTF up to the Executive Committee of the Medical Staff
  - -- Ensure a closed record system whereby patients do not leave with their records except where the commander has set policy on exceptions to the "no hand carrying" guidance
  - -- Ensure filing of medical documentation created during deployment within 30 days of members' return to home base
  - -- Enable copying of pertinent sections of patient records needed for external referral appointments
  - -- Maintain co-located guard/reserve unit personnel records in a secure area and separately from active duty records
  - -- Retire Outpatient, Inpatient, Ambulatory Procedure Visit (aka Extended

Ambulatory Record) records, and Fetal Monitor Strips to the National Personnel Record Center in St. Louis, MO using guidelines in AFI 37-138, Records Disposition – Procedures and Responsibilities

---

Scoring

4: Criteria met.

3: Criteria met in most areas. Minor administrative errors did not detract from the overall management of documentation.

2: Mechanisms in place; however, not all criteria were met appropriately. For example:
- The health record inventory was not completed IAW AFI 41-210
- Monthly review of charged out health records was not accomplished
- Active duty outpatient health record availability and accountability was consistently less than 90 percent
- There were no locally established procedures addressing health records management

1: There was minimal compliance with multiple criteria and continuity or standard of care could have been compromised. For example:
- Active duty and outpatient health record availability and accountability was consistently less than 90 percent and there were no locally established procedures to address the problem

0: Noncompliance with multiple evaluation criteria and/or basic program requirements was evident. For example:
- Serious deficiencies existed which significantly increased medico-legal concerns and/or adversely affected deployment operations
- Active duty outpatient health record availability and accountability was consistently less than 90 percent. No locally established procedures existed to address the problem, and there was widespread dissatisfaction among patients and providers

NA: Not scored.

Protocol

Administrator Protocol 3 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty MSC inspector.

Reference(s)

AFI 41-210; AFI 37-138; AFMAN 37-139; HQ USAF/SG memorandum, Supplemental Guidance on Management of Outpatient Records, 2 Aug 02

Element IG.2.5.4 (formerly HCS.1.4.3, HCS.1.4.4 and HCS.1.4.5)

Pharmacy Management

Evaluation Criteria

- Medication dispensing:
  - -- Where feasible, providers were contacted to resolve problems with prescriptions
  - -- There was a mechanism for direct pharmacist oversight of all outpatient dispensing
  - -- The pharmacy was the sole area for dispensing medications during normal pharmacy operating hours (exceptions must comply with all applicable pharmacy practice standards)
- Formulary management:
  - -- Basic core formulary was incorporated into local formulary
  - -- A revised formulary was published annually
  - -- All eligible beneficiaries received uniform standard of care to include:
    - --- All formulary medications were available for dispensing to all patients
    - --- Non-formulary purchases were not used to provide special care to groups of patients (e.g., active duty)
- Multidisciplinary pharmacy and therapeutics function met at least 4 times a year to:
  - -- Review policies, acquisition, and use of drugs at the MTF/remote sites, medication errors, and adverse drug reactions
- Evaluate clinical data on new drugs and preparations requested for MTF use

Scoring

4: Criteria met.

3: Criteria met with minor exceptions, primarily administrative in nature, that were unlikely to compromise patient care.

2: Some, but not all criteria met. An increased risk of adverse patient outcomes existed.

1: Few criteria met. The potential existed for adverse patient outcomes.

0: The organization failed to meet criteria. Adverse patient outcomes occurred or could be anticipated.

NA: Not scored.

Protocol

Senior Enlisted Protocol 1 is the pertinent protocol for this element.

Inspector Contact	For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty senior enlisted inspector.
Reference(s)	AFI 44-102

Element IG.2.5.5 (formerly HCS.1.4.1 and HCS.1.4.2)

Medication Security

Evaluation Criteria

- Medications were stored in controlled non-traffic areas under secure conditions
- There was limited access to bulk narcotic vault/safe based on pharmacy size
- Perpetual inventory was maintained for all scheduled drugs
- AF Forms 579 (or automated substitute) were issued and tracked by pharmacy and properly annotated for all controlled drugs stored outside the pharmacy
- Biennial inventory was completed on 1 May in odd years
- Monthly medical treatment facility disinterested controlled medication inventories were completed
- There was a process to detect potential medication diversion/overuse/abuse by medical treatment facility staff or patients to include witnessed destruction and documentation of unused controlled medications
- Medical unit narcotic destruction was properly conducted, witnessed and documented
  -- Narcotic inventory adjustments were documented and reviewed by chief of pharmacy and MTF commander
- Provisions of AFI 31-101, Controlled Area Security, were addressed to include:
  -- Controlled area monitors were designated in writing by unit commander
  -- Pharmacy was equipped with a minimum of two levels of intrusion detection equipment

Scoring

4: Criteria met.

3: Criteria met with minor exceptions, primarily administrative in nature, which did not detract from medication security.

2: The organization met some provisions of the criteria. The potential for misuse or diversion existed. Medications were not secure and/or inventories did not reflect actual stock on hand.

1: Adverse mission impact was expected to occur. For example:
- Medications were easily accessible to unsupervised patients
- Narcotic inventories were inaccurate
- Narcotic destruction was not witnessed

0: The organization failed to meet the criteria and was at risk for loss of DEA license. There was evidence of inappropriate storage and/or dispensing of medications.

NA: Not scored.

Protocol	Senior Enlisted Protocol 1 is the pertinent protocol for this element.
Inspector Contact	For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty senior enlisted inspector.
Reference(s)	AFI 44-102; AFI 31-101; AFMAN 23-110, Vol 5

Element IG.2.5.6 (formerly OPS.5.4.1)

Immunization Services

Evaluation Criteria

- Mechanisms were in place to ensure:
  - -- Standard procedures for determining appropriate immunization requirements and dosages
  - -- Standard procedures for supporting all immunization activities, including determining previous hypersensitivity reactions and appropriate adverse reaction reporting/documentation
  - -- Emergency care and/or emergency response was immediately available during all immunization activities (e.g., mobility processing, health fairs, annual influenza program)
  - -- Immunization waivers were appropriately coordinated and approved
  - -- An accurate database for tracking military immunization status existed
  - -- Air Force Complete Immunization Tracking Application:
    - --- Included data for special programs, e.g., influenza, hepatitis A/B, rabies and anthrax
    - --- The immunization clinic provided immunization compliance reports to commanders
  - -- Information required for the National Vaccine Injury Compensation Program (NVICP) was collected and recorded as required by AFJI 48-110 and AFMOA policy
  - -- Vaccine adverse reaction reports and filing instructions were readily accessible to providers and patients
  - -- Training of primary immunization technicians, identified immunization back up technicians (IBT), and immunization augmentees (IA) was accomplished and properly documented

Scoring

4: Criteria met.

3: There was significant compliance with criteria. Identified deficiencies were minor, primarily administrative in nature, and unlikely to compromise either mission support or patient care. For example:

- Required information for the NVICP was available, but not documented in all three recommended sites (medical record, clinical log/database, and shot record)

2: Partial compliance. Program outcomes may be adversely affected. For example:

- Required information for the NVICP was being collected but there were gaps or inaccuracies in the data
- Deficiencies in personnel knowledge or practices led to substandard patient care or negatively impacted safe and efficient immunizations

1: Minimal compliance. There was the potential for adverse patient outcomes. For example:
- Inadequate or inappropriate vaccination was administered
- Adverse reaction treatment or follow-up was inadequate or inappropriate
- NVICP information was not collected or forwarded

0: There was noncompliance to standards. The medical unit failed to meet the minimum provisions of the element. For example:
- Patients were put at unnecessary risk due to inadequate provisions for emergency care
- Increased incidence of preventable infectious diseases in a deployed workforce occurred or was highly likely to occur
- Required information for the NVICP was not being collected

NA**:** Not scored.

Protocol Senior Enlisted Protocol 2 is the pertinent protocol for this element.

Inspector Contact For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty senior enlisted inspector.

Reference(s) AFJI 48-110

Element IG.2.5.7 (formerly LED.2.3.5)

Oversight of Nursing Practice

Evaluation Criteria

- The chief nurse/superintendent provided effective oversight and utilization of nursing personnel throughout the organization
  - -- The chief nurse/superintendent established a nursing practice forum/council for the facility to provide oversight and implementation of policies related to nursing practice
  - -- A mechanism was in place to facilitate communication within nursing to include enlisted personnel
  - -- The chief nurse was a member of the executive team and collaborated with its members on policy and decision-making
  - -- The chief nurse ensured all nursing personnel were competent to perform their assigned duties
    - --- Initial and ongoing skills assessments were completed on all assigned nursing personnel
    - --- A mechanism was in place to ensure currency of valid and unrestricted nursing licenses
    - --- Made certain that the superintendent had a mechanism in place to ensure currency of emergency medical technician certifications
- A mechanism had been established to promote the professional development of all nursing personnel through in-service and continuing education, career development activities and mentoring

---

Scoring

4. Criteria met.

3. Discrepancies were minor, primarily administrative in nature, and unlikely to compromise the unit's mission and/or patient care.

2. Adverse mission support could be expected. For example:
   - The nurse executive did not function as an effective member of executive leadership
   - Evidence of oversight of nursing practice was deficient (e.g., review of policies/procedures, nursing council)
   - Although a plan was in place to assess competency of nursing staff, it was not fully implemented (e.g., incomplete competency assessments, potential existed for lapses in nursing licensure, undefined mechanism to promote professional development of all nursing personnel, in-services not documented in 6-part folders)

1. Few criteria were met. Adverse mission impact could be expected. For example:
   - A mechanism did not exist to promote the professional development

of nursing personnel, resulting in low morale and compromised career progression
- The chief nurse was not a member of the executive team
- Lapses noted in nursing licenses, Basic Life Support

0. The chief nurse failed to meet the minimum provisions of the element. Adverse mission impact occurred. For example:
   - The chief nurse provided no oversight of nursing practice
   - Nursing staff competency was questionable/compromised

NA: Not scored.

Protocol Nurse Protocol 4 is the pertinent protocol for this element.

Inspector Contact For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty nurse inspector.

Reference(s) AFI 36-2201; AFI 44-102; AFI 44-119; AFPD 46-1; AFI 46-101; AFI 46-102